STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045259	A. BUILDING _____ B. WING _____	04/06/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
THE WATERS OF WOODLAND HILLS, LLC	8701 RILEY DRIVE LITTLE ROCK, AR 72205

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** - Actual harm **Residents Affected** - Some	**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** Complaint # (AR 342) was substantiated, all or in part, with these findings. Complaint # (AR 415) was substantiated, all or in part, with these findings. Complaint # (AR 426) was substantiated, all or in part, with these findings. Complaint # (AR 429) was substantiated, all or in part, with these findings. Based on record review and interview, the facility failed to ensure residents discharged from the facility on [DATE] and [DATE], were treated with respect and dignity during the transfer process within a 24-hour period to protect residents' right and prevent increased anxiety for all 64 residents. These failed practices resulted in potential psychological harm for all 64 residents in the facility, at the time of the mass discharges according to lists provided by the Regional Director on [DATE] between 11:34 AM and 3:34 PM via emails. The findings are: I. Sample Selected Residents: 1. Resident #1 had [DIAGNOSES REDACTED]. She was admitted on [DATE]. The Significant Change in Status Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of [DATE] documented the resident scored 15 (13 - 15 indicates cognitively intact) on a Brief Interview for Mental Status (BIMS). a. On [DATE] at 1:32 PM, Resident #1 was asked via phone interview if she was upset about having to move to another facility. She said, At first I was upset. She was asked if she was given a choice to stay if she wanted to and was also asked if not, was she given a choice of where she wanted to go. She said, No, I was not given an option to stay and no option to go where I wanted to go. b. On [DATE], Resident #1's daughter was interviewed via phone and was asked if her mother received all her personal belongings when she moved. She said, No, her hearing aid and glasses did not go with her. I didn't know that they were not sent with her until (Facility #1) called me to come pick them up the following Monday ([DATE]). I took them to her after I picked them up on Monday. She went from Thursday ([DATE]) until Monday without her hearing aids and her glasses, a total of 4 days. 2. Resident #2 had [DIAGNOSES REDACTED]. She was admitted on [DATE]. The Quarterly MDS with an ARD of [DATE] documented a BIMS score of 13 (13 - 15 indicates cognitively intact). a. On [DATE] at 10:38 AM, Resident #2 was asked via phone interview if she was upset about the move and being discharged to the other facility after 11:00 PM Thursday night. She said, I don't understand why all of us had to move over here. They could have put those people somewhere else. I got moved over her about midnight. I was the last one left in the building at (Facility #1). They said we were being moved because they were going to use that building for the sick people. That new flu going around. They said everybody had to move but we could move back when this was over. I told them they would have to sterilize the building before I'll come back. 3. Resident #3 had [DIAGNOSES REDACTED]. She was admitted on [DATE]. The Annual MDS with an ARD of [DATE] documented a BIMS score of 14 (13 - 15 indicates cognitively intact). a. On [DATE] at 10:50 AM, Resident #3 was asked via phone interview if she was upset about having to move, if they told her why she was having to move, if they gave her the option of staying and if not was she given a choice of where she wanted to go. She said, We were not given an option to stay. We were told they were closing the Nursing Home down and they were turning it into a Coronavirus home, and we couldn't stay. 4. Resident #4 had [DIAGNOSES REDACTED]. She was admitted on [DATE]. The Quarterly MDS with an ARD of [DATE] documented a BIMS score of 15 (13 - 15 indicates cognitively intact). a. On [DATE] at 11:20 AM, Resident #4 was asked via phone interview if she was upset about the move, was she given an option to stay, if not, was she given a choice of where she wanted to go and if they gave her a reason for making her move. She stated, They told us we had to move because of the coronavirus they were putting people over there with [MEDICAL CONDITION] and I didn't want us to get it; so, I chose to move and not risk getting it. 5. Resident #5 had a [DIAGNOSES REDACTED]. He was admitted on [DATE]. The Quarterly MDS with an ARD of [DATE] documented a BIMS score of 15 (13 - 15 indicates cognitively intact). a. On [DATE] at 11:14 AM, Resident #5 was asked via phone interview if he was upset about having to move, was he given a reason for the move, was given an option to stay and if not was he given a choice of where he wanted to move to. He stated, I was upset about having to move because it came so sudden; no time to prepare for it. I was not given an option; I was told I had to move. They told me it was because of the coronavirus. They were going to use if for people who had [MEDICAL CONDITION]. I was not given a choice of where to move. 6. Resident #6 had [DIAGNOSES REDACTED]. He was admitted on [DATE]. The Significant Change in Status MDS with an ARD of [DATE] documented a BIMS score of 15 (13 - 15 indicates cognitively intact). a. On [DATE] at 11:14 AM, Resident #6 was asked via phone interview if he was upset about the move, was he given a reason for the move, was he given an option to stay and if not, was he given the choice of where he wanted to move to. He said, I was told the night before that I would be moving the next morning around 9 AM. I left actually about 11 - 12. They said the Federal Government was taking the building over and if you had the coronavirus you would go there. They told us that they were told at the last minute and that was the reason for such short notice. I was not given the option to stay and I had a best friend in there, but they split us up. They sent him to (Facility #4) and I'm here (Facility #2). 7. Resident #7 had [DIAGNOSES REDACTED]. He was admitted on [DATE]. The Quarterly MDS with an ARD of [DATE] documented a BIMS score of 14 (13 - 15 indicates cognitively intact). a. On [DATE] at 2:40 PM, Resident #7 was asked via a phone interview if he was upset about the move, what he was told the reason he was having to move, if he was given an option to stay and if not, was he given a choice of where he wanted to go. He said, When I first was told I had to move, I was upset about moving. They did not notify my family; I did but by the time I notified my family I had already been moved. b. On [DATE] at 3:49 PM, Resident #7 family was interviewed via phone and she was asked if she was notified prior to his move and if so when, if she was told why he had to move, if he was given an option of staying and if not, was he given a choice where he wanted to go. She said, No ma'am, I was not notified. I called him that Wednesday morning and asked if he was getting his baths. He said he was going downtown, and I said downtown where, and I told him to hang up and I was calling up there to see what was going on. I called facility and spoke with the DON (Director of Nursing) and she told me they were moving him to (Facility #6). He was there before going to (Facility #1). She told me they were moving everybody out because getting corona (coronavirus) patients. She said it was such a short notice; nobody knew anything. I was very upset about this. I would have took it better if we had gotten a letter or something and some time so we could better adjust. I don't think (Resident #7) was too happy about leaving. If they had notified me and let me know beforehand, I could have found a place that I wanted him to go. I was given no type of choice; none of us were. When I got his things, I found a paper stuck inside one of the bags that said residents' names; where they were going and what time they were going. They called me Friday morning and told me I had to get his things that day. They said they were getting patients with [MEDICAL CONDITION] on Monday. She also said that (Resident #7) wasn't given a chance; no one was given a chance to stay. 8. Resident #9 had [DIAGNOSES REDACTED]. She was admitted on [DATE]. The Admission MDS with an ARD of [DATE] documented a BIMS score of 2 (0 - 7 indicates severe cognitively impaired). a. On [DATE] at 4:20 PM, a Friend/Responsible Party of Resident #9 was interviewed via phone and was asked if she was notified prior to her being discharged , if she was given a reason for the discharge, if she was given an option of her staying and if not, was she given a choice of where she wanted to go and if

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 0550 **Level of harm -** Actual harm **Residents Affected -** Some	(continued... from page 1) she was upset about having to move. She said, I'm not sure who called me or when they called; it sounded like a male. I was told that the Nursing Home was going to be used to house the COVID-19 patients. (Resident #9) has been completely abandoned by her family and I'm all she has now. We've been friends for about [AGE] years now. She had a stroke in December, and she has been crying since then. Since I've not been able to visit her with all this going on, I don't know if this has worsened or not. 9. Resident #11 had [DIAGNOSES REDACTED]. She was admitted on [DATE]. The Annual MDS with an ARD of [DATE] documented a BIMS score of 15 (,[DATE] indicates cognitively intact). a. On [DATE] at 4:02 PM, Resident #11 was interviewed via phone and was asked if she was upset about having to move, was she given a reason for the move, was she given an option to stay and if not, was she given a choice of where she wanted to go. She said, I was upset at first. They told me they were closing down because they were going to be taking care of people with [MEDICAL CONDITION]. She said that she wasn't given an option to stay because they told us everybody had to leave. She also said she was not given a choice of where she wanted to go either. 10. Resident #12 had [DIAGNOSES REDACTED]. She was admitted on [DATE]. The significant change MDS with an ARD of [DATE] documented a BIMS score of 15 (13 - 15 indicates cognitively intact). a. On [DATE] at 3:15 PM, Resident #12 was interviewed via phone and was asked if she was upset about having to move, was she given a reason for the move, was she given an option to stay and if not, was she given a choice of where she wanted to go. She said, Yes, I was told about the move, but they let us know the night before. They told us it was because of the coronavirus and they were going to start taking people in. I was upset they were going to use that place as a quarantine area. I didn't get an option to stay or where I wanted to go. 11. Resident #13 had [DIAGNOSES REDACTED]. He was admitted on [DATE]. The significant change MDS with an ARD of [DATE] documented a BIMS score of 9 (8 - 12 indicates moderate cognitive impairment). a. On [DATE] at 3:36 PM, Resident #13 was interviewed via phone and he was asked if he was upset about having to move, was he given a reason for the move, was he given an option to stay and if not, was he given a choice of where he wanted to go. He said, I was upset because I had to move. They didn't tell me why I was moving; they just came and told me I had to move, and I was moved that day. b. On [DATE] at 3:11 PM, Resident #13's family was interviewed via phone and she was asked if he was upset about having to move, was she notified prior to him moving, was she told the reason for him moving, was he given the option to stay and if not was he given a choice on where to go. She said, Someone from there called me and told me they were moving him to (Facility #2). I can't remember when they called me though. I haven't talked to him since the transfer. They told me that (Facility #1) was a COVID facility and that's why they were notifying people. I wasn't upset because of the reason they were moving him. I knew they couldn't be there with COVID people. 12. Resident #14 had [DIAGNOSES REDACTED]. He was admitted on [DATE]. The Quarterly MDS with an ARD of [DATE] documented a BIMS score of 15 (13 - 15 indicates cognitively intact). a. On [DATE] at 3:22 PM, Resident #14 was interviewed via phone and he was asked if he was upset about having to move, was he notified prior to him moving, was he told the reason for him moving, was he given the option to stay and if not, was he given a choice on where to go. He said, My memory is not all that great . I want to say yes, I had a great deal of anxiety when they first told me, and it was rather abrupt, and it was a major stressor. I do remember being a little upset; wasn't to the point that I acted out or anything. I wished more time could have been allotted. The way we moved was like, Hey, pack it up, we got to leave. I was not given an option to stay. To my knowledge no one was given an option to stay. 13. Resident #15 had [DIAGNOSES REDACTED]. The Quarterly MDS with an ARD of [DATE] documented a BIMS score of 15 (13 -15 indicates cognitively intact). a. On [DATE] at 3:06 PM, Resident #15 was interviewed via phone and he was asked if he was upset about having to move, was he notified prior to him moving, was he told the reason for him moving, was he given the option to stay and if not was he given a choice on where to go. He said, They told me I was moving because of the overflow from the hospital to make room for people coming from the hospital. Sure, I was upset; they told me I had to move. I wasn't given an option, they said they needed the beds. I was upset, I didn't know what place they were sending me. 14. Resident #16 had [DIAGNOSES REDACTED]. He was admitted on [DATE]. The Quarterly MDS with an ARD of [DATE] documented a BIMS score of 15 (13 - 15 indicates cognitively intact). a. On [DATE] at 12:43 PM, Resident #16 was interviewed via phone and he was asked if he was upset about having to move, was he notified prior to him moving, was he told the reason for him moving, was he given the option to stay and if not was he given a choice on where to go. He said, I wasn't upset about it, but they didn't give me a notice. I found out I was being moved about 10 minutes prior to the move. II. Non-Sample Selected Resident Interviews: 1. On [DATE] at 2:20 PM an interview was conducted via phone with a Non-Sample Selected Resident and was asked if she was upset about the move, told the reason for the move, was given an option to stay and if not, was she given a choice of where they wanted to go. She stated, My sugar had dropped to 31. They (Facility #1) sent me out to (Hospital #1). I stayed there until I was stable; about 3 days, then I was sent to (Facility #6). I thought I was going back to (Facility #1) but they sent me here (Facility #6). I don't know why they sent me here. I think they called my momma after they got me here. I told them (Facility #6) I wanted to talk to my momma because my phone was dead since I didn't have my phone charger with me. After I got my phone charger and charged my phone, I called my momma and told her where I was at. a. At 2:33 PM, surveyor spoke with (Facility #6) Administrator and asked him if and when he notified the above Resident's momma that she was sent here; and not (Facility #1). He said, I talked to her mother the day she got here. They (Facility #1) had not told her that she would not be going back there. 2. On [DATE] at 2:32 PM, an interview was conducted via phone with a Non-Sample Selected Resident and was asked if she was upset about the move, told the reason for the move, was given an option to stay and if not, was she given a choice of where they wanted to go. She said, I was not told reason I was moving, and I was not given a choice on where I was moving too, and no one came and told me I was going to be moving before they moved me. 3. On [DATE] at 2:37 PM, an interview was conducted via phone with a Non-Sample Selected Resident and was asked if she was upset about the move, told the reason for the move, was given an option to stay and if not, was he given a choice of where they wanted to go. He said, I was not given an option to stay. No, no reason given either; just told me we had to move. No, not given any options. 4. On [DATE] at 3:50 PM, an interview was conducted via phone with a Non-Sample Selected Resident and was asked if he was upset about the move, told the reason for the move, was given an option to stay and if not, was he given a choice of where they wanted to go. He said, I don't think they gave me an option to stay. They told us it was because of the flu. 5. On [DATE] at 4:44 PM, an interview was conducted via phone with a Non-Sample Selected Resident and was asked if he was upset about the move, told the reason for the move, was given an option to stay and if not, was given a choice of where they wanted to go. He said, I was not given a reason for moving. I was upset about having to move. I was not given an option to stay. I was not given a choice of what facility I wanted to go to. 6. On [DATE] at 4:46 PM, an interview was conducted via phone with a Non-Sample Selected Resident and was asked if he was upset about the move, told the reason for the move, was given an option to stay and if not, was she given a choice of where they wanted to go. She said, I was not given an option to stay. I was not given a choice of what facility I wanted to go to. I was upset about moving because they did it all in one day. The (Certified Nurse Assistant) CNAs told me as they were moving me it was because they were going to be moving peoples with the coronavirus in there. 7. On [DATE] at 5:05 PM, an interview was conducted via phone with a Non-Sample Selected Resident and was asked if he was upset about the move, told the reason for the move, was given an option to stay and if not was given a choice of where they wanted to go. She said, I was not given an option to stay and I don't think I was given a choice of where I wanted to go. Yes, I was upset about moving. You get in a routine and get secure with it and it gets pulled out from under you. They said I was having to move because they were putting the COVID-19 in there. They told me I was having to move, and they moved me the next day. III. Non-Sampled Resident Family Interviews: 1. On [DATE] at 10:15 AM, an interview was conducted via phone with a Non-Sample Selected Residents Family and they were asked if they were upset about their loved one having to move, were they notified prior to them moving and if so when, if they were given an option to stay if not, were they given a choice of where they wanted them to go. They said, I was very upset. They called me late in the evening and told me they were moving her the next day. They picked the Nursing Home and I never had a chance to check it out. I was not given an option of her to stay at (Facility #1). They said she had to go. She was transferred to (Facility #8). We called (Facility #8) that evening as soon as they called, and they accepted her. 2. On [DATE] At 10:22 AM, an interview was conducted via phone with a Non-Sample Selected Residents Family and they were asked if they were upset about their loved one having to move, were they notified prior to them moving and if so when, if they were given an option to stay if not, were they given a choice of where they wanted them to go. They said, We were very upset. I was feeling very dissatisfied with the Nursing Home prior to the transfer of the Residents. I had contacted another facility (Facility #9) about transferring my mother. My mother had been at (Facility #1) for 5-plus years. We had been unhappy but kept her there because of the CNA's who had been with her all of these years. We were disappointed with management staff. We were not aware of them getting ready to ship everyone out. Another patient's family member told me. I told her they haven't called us. I called (Facility #1) and asked them what's going on. I asked if they had the coronavirus and I was told no. I told them they knew we were in the process of moving my mother and they said we

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F 0550 **Level of harm -** Actual harm **Residents Affected -** Some	(continued... from page 2) had to have her out by Thursday. I talked to the facility; I think it was the 17th; then I was panicking. I called the other facility and told them what was going on and how could I expedite. (Facility #1) told me she was going to (Facility #3). They knew we were in the process of going to (Facility #9). They had already sent all of the paperwork to (Facility #9). I kept asking them, Why, why, why are you doing this? I was worried about how my mother was going to react because we haven't been able to visit. The same day I learned they were going to transfer her, I told her please wait, I'm on my way there. When I got there, I was unable to get in. Someone let me in and then they told me you can't come in here. My mother is at (Facility #8). This whole ordeal was a total nightmare. They should have notified us. 3. On [DATE] at 11:08 AM, an interview was conducted via phone with a Non-Sample Selected Residents Family and they were asked if they were upset about their loved one having to move, were they notified prior to them moving and if so when, if they were given an option to stay if not, were they given a choice of where they wanted them to go. They said, I got a call from someone at the facility, they left a message. I couldn't completely understand what they were saying. I immediately called back. I think her name was (Licensed Practical Nurse (LPN) #2). They couldn't get her to the phone. I left a message with (Employee #3). I told her I was calling about the message they had left about transferring her. I told her they better not transfer her until I knew where she was going. They did not give me an option of where she was going. Said she was going to one of their sister facility's. They notified me one day in advance. They did not tell me why until I went to get some of her things after she was already transferred. They told us they were going to move all of her things, but they didn't. When we got there, they had 4 of those contractor trash bags full of stuff. When we went and got her things, I was told they were going to be housing COVID patients. It took a week of calling and finally threatening them to take her TV off the wall so I could get it picked up because I wasn't going in there after the COVID patients got there. I talked to (CNA #3) and he said he would let (Maintenance Director) know. Then I talked to the (Business Office Manager, (BOM)) about her account. She suggested I send an email to the Administrator regarding the TV. I had it the next day. My mom didn't throw too much of a fit. She was at (Facility #6) prior to (Facility #1). When someone at (Facility #6) called me, she said she wanted to let me know where my mother was going. I told her she is supposed to be going to (Facility #6). She said she was calling because some of the other Resident families didn't know they were or where they were going. My big thing was I didn't understand the big rush. III. Observations: On [DATE] multiple snap shots of the video footage on [DATE] and [DATE] were received by (Employee #1) via email. They included pictures of multiple large contractor trash bags and plastic and cardboard boxes full of Resident personal belongings piled on top of wheelchairs, serving carts, tables and floor. There were also pictures of clusters of various non-bagged or non-boxed unidentifiable items. Amongst the clutter were some pictures of residents in wheelchairs and/or chairs as well as multiple staff members; including the Maintenance Director. (Photos are available for further details) IV. Staff Interviews: 1. On [DATE] at 12:10 PM, (Employee #1) called and stated that she was so upset about what happened to their residents that were sent out of their facilities on the 18th and 19th. They were pulled out of their beds and put in their wheelchairs and put out in the hallways lined up like cattle. (Resident #11) was crying and non-sample selected Resident and (Resident #3) were very mad and (Resident #6) was very upset and he went to hospital for [MEDICAL TREATMENT] 3 times a week. Also, (Resident #9) (non-verbal) was so upset she was crying (more than usual), also (Resident #12, #13, #14 and #15) were also upset about the move and (Resident #10) passed away right after the move but I don't know what he died from. 2. On [DATE] at 12:45 PM, (Contracted Staff #1) called and reported that he assisted with transporting 8 residents on Wednesday and 4 - 5 residents on Thursday. He said that he had been transporting (Resident #6) previously to [MEDICAL TREATMENT] before he was discharged from that facility. He said that (Resident #6) was appalled and furious about having to move. He also said that since last Thursday all of the residents' personal belongings were in trash bags and sitting in the lobby and hallway in front at (Facility #2) which saddened me since so many of these residents that is all they have left to their name and it was tossed about like it was nothing. Seemed as though they weren't thinking or caring about the Residents' wellbeing. He went on to say that the only person he currently trusted was the previous Administrator; that they have fired for not lying to us. He said that he was witnessed to families not being told that their loved ones were being moved, patients belongings in trash bags out in the hallways of (Facility #1) and it appeared that some of the residents whom he transported had not received care before they were sent out. He said that he also heard last Friday the DON and Social Service Director talking about throwing away residents' personal belongings and heard (Nurse Consultant) saying to them, We're not taking their things to them and I don't care what you do with them; toss them for all I care. He was asked if he was aware of the last resident being sent out late the night of the 19th. He said, Yes, I can attest to that because they asked me to transport (Resident #2) around 11:00 PM that night but I was already on my way to (out of state) and was not able to do that transfer. 3. On [DATE] at 4:11 PM, spoke to LPN #2 via phone. She was asked what her involvement was in the mass discharge of the facility's previous residents on the 18th and 19th. She said, On Tuesday, I believe it was the 17th, (Nurse Consultant) from Corporate came in the building around 9:00 to 10:00 and told all of the Department Heads that we would be moving all of the residents out of this facility within the next 2 days because we are going to be a designated COVID-19 facility. We were given a typed message of what we were to tell the Residents/Families. They should be able to get you a copy of that letter. They also had a list of the residents and where they were going to be transferred to so we could get them lined up awaiting transfer to the various facilities. We all had a certain hall we were assigned to go call the POAs (Power of Attorneys) or tell the residents what was going on. Another staff member and I had the (E) hall. I tried to put in the Residents Progress Notes who I talked to but, I don't know about my partner or any of the other ones what they did or told the residents and/or their families. I have been so upset about all this; spent all weekend crying. They did it in such a way that stripped them (Residents) of their dignity, rights and basically left them in a very fragile emotional state of mind. They were lined up like cattle going to slaughterhouses. They tossed all of their belongings out in the hallways in trash bags and many of the residents saw what was happening to all of their personal belongings. (Resident #8) was sitting at the back with other residents they had lined up awaiting transport. He waved at me and I went back to him and he was unable to talk but was shaking his head; grabbed my arm hanging onto it. I told him it was going to be okay and he would be taken care of. But I felt like I was lying to him trying to make him feel better about what was going on. (Resident #9) is a very depressed resident and has a tendency to cry anyway; she was sitting in her wheelchair with tears running down her face. I tried to console her as well. She is non-verbal most of the time. (Resident #5) was in his room and he asked me, 'Can you tell me where he's going (pointing at his roommate; (Resident #10). He said I'd like to go where he's going because I've always looked after him.' I told him I would check. I did but, they did send them to separate facilities. I was told (Resident #10) expired shortly after the move but I do not know what from. I felt like the DON, SSD could care less and just wanted to get this done. The DON did not come out of her office much at all on the 18th and 19th to help us nor console any of the residents. There was no notice given to anyone and no one was given an option to stay. 4. On [DATE] at 4:35 PM, an interview was done with Employee #3 and she was asked what her involvement was when all of the previous residents were all sent out to other facilities on the 18th and 19th of March. She said, (Regional Director) and (Nurse Consultant) told us through the DON and the Previous Administrator to tell State the residents had a choice if they wanted to move or stay and choice of facility. None of the Resident's wanted to move. (Resident #11) cried and (Resident #6) told them You are violating my (expletive) rights! He voiced this when he was going out the door. The (Non-Sample Selected Resident's) family was upset, another (Non-sample Selected Resident's) family was upset, also (Non-sampled Selected Resident's) and (Resident #16) families were upset as well as another (Non-sampled Selected Resident's) family was upset. They all knew about all of this too. II. Policy and Procedures: The Resident Rights provided by the Administrator on [DATE] at 11:11 AM documented, .Resident Rights. a.) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to person and services inside and outside the facility, including those specified in this section. (1) a facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. (2) . a facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. b). Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. (1) the facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility (2) the resident has the right to be free from interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supportive by the facility in the exercise of his or her rights as required under this subpart. (3) in the case that the resident who has not been adjudged incompetent by the State/Court, the resident has the right to

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	045259	A. BUILDING _____ B. WING _____	**04/06/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
THE WATERS OF WOODLAND HILLS, LLC	**8701 RILEY DRIVE LITTLE ROCK, AR 72205**

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 -** Actual harm **Residents Affected -** Some	(continued... from page 3) designate a representative, in accordance with State law and any legal surrogate so designated may exercise the resident rights to the extent provided by State law (i.) the resident representative has the right to exercise the resident rights to the extent those rights are delegated to the resident representative. (ii.) the resident retains the right to exercise those rights not delegated to a resident representative, including the right to revoke a delegation of rights,

F 0580 **Level of harm -** Actual harm **Residents Affected -** Some	**Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Complaint # (AR 342) was substantiated, all or in part, with these findings. Complaint # (AR 415) was substantiated, all or in part, with these findings. Complaint # (AR 426) was substantiated, all or in part, with these findings. Complaint # (AR 429) was substantiated, all or in part, with these findings. Based on record review and interviews the facility failed to ensure Residents and/or Responsible Parties were notified promptly, in writing or via phone call, prior to discharging residents from the facility on 3/18/20 and 3/19/20 to promote resident well-being and keep residents' responsible parties informed. This failed practice had the potential to affect all 64 residents discharged from the facility on 3/18/20 and 3/19/20 per emails received from the Regional Director on 3/25/2020 between 11:34 AM and 3:34 PM. The findings are: I. Sample Selected Residents: 1. Resident #1 had [DIAGNOSES REDACTED]. She was admitted on [DATE]. The Significant Change in Status Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 1/20/20 documented the resident scored 15 (13-15 indicates cognitively intact) on a Brief Interview for Mental Status (BIMS). a. On 3/27/2020 at 1:32 PM, Resident #1 was asked via phone interview if she was upset about having to move to another facility. She said, At first I was upset. She was asked if she was given a choice to stay if she wanted to and was also asked if not, was she given a choice of where she wanted to go. She said, No, I was not given an option to stay and no option to go where I wanted to go. b. On 4/2/2020 Resident #1 daughter was interviewed via phone and was asked if her mother received all her personal belongings when she moved. She said, No, her hearing aid and glasses did not go with her. I didn't know that they were not sent with her until (Facility #1) called me to come pick them up the following Monday (3/23/20). I took them to her after I picked them up on Monday. She went from Thursday (3/19/20) until Monday without her hearing aids and her glasses, a total of 4 days. 2. Resident #2 had [DIAGNOSES REDACTED]. She was admitted on [DATE]. The Quarterly MDS with an ARD of 2/28/20 documented a BIMS score of 13 (13-15 indicates cognitively intact). a. On 3/27/2020 at 10:38 AM, Resident #2 was asked via phone interview if she was upset about the move and being discharged to the other facility after 11:00 PM Thursday night. She said, I don't understand why all of us had to move over here. They could have put those people somewhere else. I got moved over her about midnight. I was the last one left in the building at (Facility #1). They said we were being moved because they were going to use that building for the sick people. That new flu going around. They said everybody had to move but we could move back when this was over. I told them they would have to sterilize the building before I'll come back. 3. Resident #3 had [DIAGNOSES REDACTED]. She was admitted on [DATE]. The Annual MDS with an ARD of 12/25/19 documented a BIMS score of 14 (13-15 indicates cognitively intact). a. On 3/27/2020 at 10:50 AM, Resident #3 was asked via phone interview if she was upset about having to move, if they told her why she was having to move, if they gave her the option of staying and if not was she given a choice of where she wanted to go. She said, We were not given an option to stay. We were told they were closing the Nursing Home down and they were turning it into a Coronavirus home, and we couldn't stay. 4. Resident #4 had [DIAGNOSES REDACTED]. She was admitted on [DATE]. The Quarterly MDS with an ARD of 2/3/20 documented a BIMS score of 15 (13-15 indicates cognitively intact). a. On 3/27/2020 at 11:20 AM, Resident #4 was asked via phone interview if she was upset about the move, was she given an option to stay, if not, was she given a choice of where she wanted to go and if they gave her a reason for making her move. She stated, They told us we had to move because of the coronavirus they were putting people over there with [MEDICAL CONDITION] and I didn't want us to get it; so, I chose to move and not risk getting it. 5. Resident #5 had a [DIAGNOSES REDACTED]. He was admitted on [DATE]. The Quarterly MDS with an ARD of 1/24/20 documented a BIMS score of 15 (13-15 indicates cognitively intact). a. On 3/27/2020 at 11:14 AM, Resident #5 was asked via phone interview if he was upset about having to move, was he given a reason for the move, was given an option to stay and if not was he give a choice of where he wanted to move to. He stated, I was upset about having to move because it came so sudden; no time to prepare for it. I was not given an option; I was told I had to move. They told me it was because of the coronavirus. They were going to use if for people who had [MEDICAL CONDITION]. I was not given a choice of where to move. 6. Resident #6 had [DIAGNOSES REDACTED]. He was admitted on [DATE]. The Significant Change in Status MDS with an ARD of 1/30/20 documented a BIMS score of 15 (13-15 indicates cognitively intact). a. On 3/27/2020 at 11:14 AM, Resident #6 was asked via phone interview if he was upset about the move, was he given a reason for the move, was he given an option to stay and if not, was he given the choice of where he wanted to move to. He said, I was told the night before that I would be moving the next morning around 9 AM. I left actually about 11 to 12. They said the Federal Government was taking the building over and if you had the coronavirus you would go there. They told us that they were told at the last minute and that was the reason for such short notice. I was not given the option to stay and I had a best friend in there, but they split us up. They sent him to (Facility #4) and I'm here (Facility #2). 7. Resident #7 had [DIAGNOSES REDACTED]. He was admitted on [DATE]. The Quarterly MDS with an ARD of 12/19/19 documented a BIMS score of 14 (13-15 indicates cognitively intact). a. On 3/27/20 at 2:40 PM, Resident #7 was asked via a phone interview if he was upset about the move, what he was told the reason he was having to move, if he was given an option to stay and if not, was he given a choice of where he wanted to go. He said, When I first was told I had to move, I was upset about moving. They did not notify my family; I did but, by the time I notified my family I had already been moved. b. On [DATE]/2020 at 3:49 PM, Resident #7 family was interviewed via phone and she was asked if she was notified prior to his move and if so when, if she was told why he had to move, if he was given an option of staying and if not, was he given a choice where he wanted to go. She said, No ma'am, I was not notified. I called him that Wednesday morning and asked if he was getting his baths. He said he was going downtown, and I said downtown where, and I told him to hang up and I was calling up there to see what was going on. I called facility and spoke with the DON (Director of Nursing) and she told me they were moving him to (Facility #6). He was there before going to (Facility #1). She told me they were moving everybody out because getting corona (coronavirus) patients. She said it was such a short notice; nobody knew anything. I was very upset about this. I would have took it better if we had gotten a letter or something and some time so we could better adjust. I don't think (Resident #7) was too happy about leaving. If they had notified me and let me know beforehand, I could have found a place that I wanted him to go. I was given no type of choice; none of us were. When I got his things, I found a paper stuck inside one of the bags that said residents' names; where they were going and what time they were going. They called me Friday morning and told me I had to get his things that day. They said there were getting patients with [MEDICAL CONDITION] on Monday. She also said that (Resident #7) wasn't given a chance; no one was given a chance to stay. 8. Resident #9 had [DIAGNOSES REDACTED]. She was admitted on [DATE]. The Admission MDS with an ARD of 2/12/20 documented a BIMS score of 2 (0-7 indicates severe cognitively impaired). a. On [DATE]/2020 at 4:20 PM, a Friend/Responsible Party of Resident #9 was interviewed via phone and was asked if she was notified prior to her being discharged , if she was given a reason for the discharge, if she was given an option of her staying and if not, was she given a choice of where she wanted to go and if she was upset about having to move. She said, I'm not sure who called me or when they called; it sounded like a male. I was told that the Nursing Home was going to be used to house the COVID-19 patients. (Resident #9) has been completely abandoned by her family and I'm all she has now. We've been friends for about [AGE] years now. She had a stroke in December, and she has been crying since then. Since I've not been able to visit her with all this going on, I don't know if this has worsened or not. 9. Resident #11 had [DIAGNOSES REDACTED]. She was admitted on [DATE]. The Annual MDS with an ARD of 2/7/20 documented a BIMS score of 15 (13-15 indicates cognitively intact). a. On 3/27/2020 at 4:02 PM, Resident #11 was interviewed via phone and was asked if she was upset about having to move, was she given a reason for the move, was she given an option to stay and if not, was she given a choice of where she wanted to go. She said, I was upset at first. They told me they were closing down because they were going to be taking care of people with [MEDICAL CONDITION]. She said that she wasn't given an option to stay because they told us everybody had to leave. She also said she was not given a choice of where she wanted to go either. 10. Resident #12 had [DIAGNOSES REDACTED]. She was admitted on [DATE]. The significant change MDS with an ARD of 1/4/20 documented a BIMS score of 15 (13-15 indicates cognitively intact). a. On 3/21/2020 at 3:15 PM, Resident #12 was interviewed via phone and was asked if she was upset about having to move, was she given a reason for the move, was she given an option to stay and if not, was she given a choice of where she wanted to go. She said, Yes, I was told about the move, but they let us know

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F 0580 **Level of harm -** Actual harm **Residents Affected -** Some	(continued... from page 4) the night before. They told us it was because of the [MEDICAL CONDITION] and they were going to start taking people in. I was upset they were going to use that place as a quarantine area. I didn't get an option to stay or where I wanted to go. 11. Resident #13 had [DIAGNOSES REDACTED]. He was admitted on [DATE]. The significant change MDS with an ARD of 1/25/20 documented a BIMS score of 9 (8-12 indicates moderate cognitive impairment). a. On [DATE]/20 at 3:36 PM, Resident #13 was interviewed via phone and he was asked if he was upset about having to move, was he given a reason for the move, was he given an option to stay and if not, was he given a choice of where he wanted to go. He said, I was upset because I had to move. They didn't tell me why I was moving; they just came and told me I had to move, and I was moved that day. b. On [DATE]/20 at 3:11 PM, Resident #13's family was interviewed via phone and she was asked if he was upset about having to move, was she notified prior to him moving, was she told the reason for him moving, was he given the option to stay and if not was he given a choice on where to go. She said, Someone from there called me and told me they were moving him to (Facility #2). I can't remember when they called me though. I haven't talked to him since the transfer. They told me that (Facility #1) was a COVID facility and that's why they were notifying people. I wasn't upset because of the reason they were moving him. I knew they couldn't be there with COVID people. 12. Resident #14 had [DIAGNOSES REDACTED]. He was admitted on [DATE]. The Quarterly MDS with an ARD of 2/19/20 documented a BIMS score of 15 (13-15 indicates cognitively intact). a. On 3/27/20 at 3:22 PM, Resident #14 was interviewed via phone and he was asked if he was upset about having to move, was he notified prior to him moving, was he told the reason for him moving, was he given the option to stay and if not, was he given a choice on where to go. He said, My memory is not all that great . I want to say yes, I had a great deal of anxiety when they first told me, and it was rather abrupt, and it was a major stressor. I do remember being a little upset; wasn't to the point that I acted out or anything. I wished more time could have been allotted. The way we moved was like, Hey, pack it up, we got to leave. I was not given an option to stay. To my knowledge no one was given an option to stay. 13. Resident #15 had [DIAGNOSES REDACTED]. The Quarterly MDS with an ARD of 3/15/20 documented a BIMS score of 15 (13-15 indicates cognitively intact). a. On 3/27/20 at 3:06 PM, Resident #15 was interviewed via phone and he was asked if he was upset about having to move, was he notified prior to him moving, was he told the reason for him moving, was he given the option to stay and if not was he given a choice on where to go. He said, They told me I was moving because of the overflow from the hospital to make room for people coming from the hospital. Sure, I was upset; they told me I had to move. I wasn't given an option, they said they needed the beds. I was upset, I didn't know what place they were sending me. 14. Resident #16 had [DIAGNOSES REDACTED]. He was admitted on [DATE]. The Quarterly MDS with an ARD of 2/15/20 documented a BIMS score of 15 (13-15 indicates cognitively intact). a. On [DATE]/20 at 12:43 PM, Resident #16 was interviewed via phone and he was asked if he was upset about having to move, was he notified prior to him moving, was he told the reason for him moving, was he given the option to stay and if not was he given a choice on where to go. He said, I wasn't upset about it, but they didn't give me a notice. I found out I was being moved about 10 minutes prior to the move. II. Non-Sample Selected Resident Interviews: 1. On 3/27/20 at 2:20 PM, an interview was conducted via phone with a Non-Sample Selected Resident and was asked if she was upset about the move, told the reason for the move, was given an option to stay and if not, was she given a choice of where they wanted to go. She stated, My sugar had dropped to 31. They (Facility #1) sent me out to (Hospital #1). I stayed there until I was stable; about 3 days, then I was sent to (Facility #6). I thought I was going back to (Facility #1) but they sent me here (Facility #6). I don't know why they sent me here. I think they called my momma after they got me here. I told them (Facility #6) I wanted to talk to my momma because my phone was dead since I didn't have my phone charger with me. After I got my phone charger and charged my phone, I called my momma and told her where I was at. a. At 2:33 PM, surveyor spoke with (Facility #6) Administrator and asked him if and when he notified the above Resident's momma that she was sent here; and not (Facility #1). He said, I talked to her mother the day she got here. They (Facility #1) had not told her that she would not be going back there. 2. On 3/27/20 at 2:32 PM, an interview was conducted via phone with a Non-Sample Selected Resident and was asked if she was upset about the move, told the reason for the move, was given an option to stay and if not, was she given a choice of where they wanted to go. She said, I was not told reason I was moving, and I was not given a choice on where I was moving too, and no one came and told me I was going to be moving before they moved me. 3. On 3/27/20 at 2:37 PM, an interview was conducted via phone with a Non-Sample Selected Resident and was asked if she was upset about the move, told the reason for the move, was given an option to stay and if not, was he given a choice of where they wanted to go. He said, I was not given an option to stay. No, no reason given either; just told me we had to move. No, not given any options. 4. On 3/27/20 at 3:50 PM, an interview was conducted via phone with a Non-Sample Selected Resident and was asked if he was upset about the move, told the reason for the move, was given an option to stay and if not, was he given a choice of where they wanted to go. He said, I don't think they gave me an option to stay. They told us it was because of the flu. 5. On 3/27/20 at 4:44 PM, an interview was conducted via phone with a Non-Sample Selected Resident and was asked if he was upset about the move, told the reason for the move, was given an option to stay and if not, was given a choice of where they wanted to go. He said, I was not given a reason for moving. I was upset about having to move. I was not given an option to stay. I was not given a choice of what facility I wanted to go to. 6. On 3/27/20 at 4:46 PM, an interview was conducted via phone with a Non-Sample Selected Resident and was asked if he was upset about the move, told the reason for the move, was given an option to stay and if not, was he given a choice of where they wanted to go. She said, I was not given an option to stay. I was not given a choice of what facility I wanted to go to. I was upset about moving because they did it all in one day. The (Certified Nurse Assistant) CNA's told me as they were moving me it was because they were going to be moving peoples with the coronavirus in there. 7. On 3/27/20 at 5:05 PM, an interview was conducted via phone with a Non-Sample Selected Resident and was asked if he was upset about the move, told the reason for the move, was given an option to stay and if not was given a choice of where they wanted to go. She said, I was not given an option to stay and I don't think I was given a choice of where I wanted to go. Yes, I was upset about moving. You get in a routine and get secure with it and it gets pulled out from under you. They said I was having to move because they were putting the COVID-19 in there. They told me I was having to move, and they moved me the next day. III. Non-Sampled Resident Family Interviews: 1. On [DATE]/20 at 10:15 AM, an interview was conducted via phone with a Non-Sample Selected Residents Family and they were asked if they were upset about their loved one having to move, were they notified prior to them moving and if so when, if they were given an option to stay if not, were they given a choice of where they wanted them to go. They said, I was very upset. They called me late in the evening and told me they were moving her the next day. They picked the Nursing Home and I never had a chance to check it out. I was not given an option of her to stay at (Facility #1). They said she had to go. She was transferred to (Facility #8). We called (Facility #8) that evening as soon as they called, and they accepted her. 2. On [DATE]/20 At 10:22 AM, an interview was conducted via phone with a Non-Sample Selected Residents Family and they were asked if they were upset about their loved one having to move, were they notified prior to them moving and if so when, if they were given an option to stay if not, were they given a choice of where they wanted them to go. They said, We were very upset. I was feeling very dissatisfied with the Nursing Home prior to the transfer of the Residents. I had contacted another facility (Facility #9) about transferring my mother. My mother had been at (Facility #1) for 5-plus years. We had been unhappy but kept her there because of the CNA's who had been with her all of these years. We were disappointed with management staff. We were not aware of them getting ready to ship everyone out. Another patient's family member told me. I told her they haven't called us. I called (Facility #1) and asked them what's going on. I asked if they had the coronavirus and I was told no. I told them they knew we were in the process of moving my mother and they said we had to have her out by Thursday. I talked to the facility; I think it was the 17th; then I was panicking. I called the other facility and told them what was going on and how could I expedite. (Facility #1) told me she was going to (Facility #3). They knew we were in the process of going to (Facility #9). They had already sent all of the paperwork to (Facility #9). I kept asking them, Why, why, why are you doing this? I was worried about how my mother was going to react because we haven't been able to visit. The same day I learned they were going to transfer her, I told her please wait, I'm on my way there. When I got there, I was unable to get in. Someone let me in and then they told me you can't come in here. My mother is at (Facility #8). This whole ordeal was a total nightmare. They should have notified us. 3. On [DATE]/20 at 11:08 AM, an interview was conducted via phone with a Non-Sample Selected Residents Family and they were asked if they were upset about their loved one having to move, were they notified prior to them moving and if so when, if they were given an option to stay if not, were they given a choice of where they wanted them to go. They said, I got a call from someone at the facility, they left a message. I couldn't completely understand what they were saying. I immediately called back. I think her name was (Licensed Practical Nurse (LPN) #2). They couldn't get her to the phone. I left a message with (Employee #3). I told her I was calling about the message they had left about transferring her. I told her they better not transfer her until I knew where she was going. They did not give me an option of where she was going. Said she was

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0580 **Level of harm** - Actual harm **Residents Affected** - Some	(continued... from page 5) going to one of their sister facility's. They notified me one day in advance. They did not tell me why until I went to get some of her things after she was already transferred. They told us they were going to move all of her things, but they didn't. When we got there, they had 4 of those contractor trash bags full of stuff. When we went and got her things, I was told they were going to be housing COVID patients. It took a week of calling and finally threatening them to take her TV off the wall so I could get it picked up because I wasn't going in there after the COVID patients got there. I talked to (CNA #3) and he said he would let (Maintenance Director) know. Then I talked to the (Business Office Manager, (BOM)) about her account. She suggested I send an email to the Administrator regarding the TV. I had it the next day. My mom didn't throw too much of a fit. She was at (Facility #6) prior to (Facility #1). When someone at (Facility #6) called me, she said she wanted to let me know where my mother was going. I told her she is supposed to be going to (Facility #6). She said she was calling because some of the other Resident families didn't know they were or where they were going. My big thing was I didn't understand the big rush. IV. Policies and Procedures: A. Rapid Response Plan COVID-19 March 13, 2020 (Developed by (Corporation)) documented, Purpose: Out of an abundance of caution and in an effort to contain or mitigate the spread of COVID-19 . Plan: .Contact each resident and resident representative of the designated facilities to obtain permission to temporarily relocate . B. COVID-19 Emergency Declaration Blanket Waivers for Health Care Providers Centers of Medicare /and Medicaid (CMS) documented, Resident Transfer/Discharge: .Exceptions: .In 483.10, we are only waiving the requirement, under 483.10(c)(5), that a facility provide advance notification of options relating to the transfer or discharge to another facility. Otherwise all requirement, under 483.15(c)(3), (c)(4)(ii), (c)(5)(i) and (iv), and (d), for the written notice of transfer or discharge to be provided before the transfer or discharge. This notice must be provided as soon as practicable . (Corporation) had developed their Rapid Response plan on 3/13/2020 and could have provided sufficient notice as early as 3/13/2020 or immediately thereafter; NOT the day before, day of or after their discharge. .We reminded Office of Long-Term Care (OLTC) facilities that they are responsible for ensuring that any transfers (either within a facility, or to another facility) are conducted in a safe and orderly manner, and that each resident's health and safety is protected . C. The (Facility #1) letter dated 3/17/2020 read (not given and/or sent) to some of the Resident and/or Responsible Party either on 3/17/20, 3/18/20, or 3/19/20 documented, 3/17/2020 . Dear Resident, Family and/or Responsible Party, Due to the illnesses that are occurring with the COVID crisis, we are designating our Facility, (Facility #1) as a COVID-19 facility due to our unique situation of having an isolated building. We do not have any active cases at this point but are planning on this occurring in the near future due to the outbreak. Therefore, we will be moving you (your loved one) to one of our sister facilities: _____ .
F 0600 **Level of harm** - Actual harm **Residents Affected** - Some	**Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record reviews and interviews, the facility failed to ensure residents were informed in writing or verbal communication; in a language they could understand of the need to move from the current facility to another sister facility to prevent potential transmission of the Coronavirus; Failed to ensure the mass transfers was done decent, and in order, with minimum stress, chaos and disruption to minimize mental anguish, emotional distress for all 64 residents. This failed practice resulted in psychological abuse and harm for all 64 residents who resided in the facility during the time of the mass discharges per lists provided by the Regional Director on 3/25/2020 between 11:34 AM and 3:34 PM via emails. The findings are: I. Sample Selected Residents: 1. Resident #1 had [DIAGNOSES REDACTED]. She was admitted on [DATE]. The Significant Change in Status Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 1/20/20 documented the resident scored 15 (13 - 15 indicates cognitively intact) on a Brief Interview for Mental Status (BIMS). a. On 3/24/2020 at 3:22 PM, spoke with Resident #1's daughter and was asked if she was aware of the reason for her mother's discharge from the facility and when she was notified of her impending discharge and if she was given a choice of which facility she wanted her mother to be discharged to and if she was given an option of her mother staying at the facility and not being discharged . She stated, I found out initially from mother's (Attending Physician #1's) (Advanced Practice Nurse) that the facility where my mother has been for approximately [AGE] years was discharging all of their residents out by the following Monday to their sister facilities. She knew I wanted my mother to go to (Facility #7) so she was nice enough to call me and give me a heads up. She also said she didn't hear from the facility about this until approximately around 10:30 - 11:00 AM on the 19th that they needed approval from (Facility #7) in 5 minutes if they were going to admit her mother or not. She said she immediately called (Facility #7) and told them that (Facility #1) was ready to transfer her mother right then. They (Facility #7) initially told me that all they needed from (Facility #1) was a Pre-Admission and Screening Resident Review (PASARR). She said she then attempted to call (Facility #1) back and never got an answer nor did it ring or give her a busy signal. It would just immediately after dialing just drop the call. She said that was when she called (Facility #7) back and told them of the situation and they told me I'd need to go there and come back to complete admission paperwork and give a deposit to hold the room. She said she immediately went to (Facility #7). Said it was approximately 45 minutes after she spoke to them and while she was there completing paperwork she got another call from (APRN) and asked what was going on at (Facility #1) because they couldn't get anyone there to answer the phone either. She said she then told the lady at (Facility #7) that she needed to go to (Facility #1) and see what was going on. She said she got there around 3:00 PM and her mother was already gone. She asked where they (Facility #1) sent her and they told her (Facility #7) and that's when she became irate and told them No .you didn't send her there (Facility #7) .I just came from there!!! And was screaming at them, Where is my mother? over and over when they finally told her that they had sent her to (Facility #4) since (Facility #7) would not accept her mother. She said she told them that (Facility #7) and herself had been trying to get in touch with them all day to tell them they just needed a (PASARR) and that was when the Administrator and the SSD (Social Service Director) told her no, they had been in contact with (Facility #7) multiple times throughout the day and the conversation became very heated at that point to the point a male (unknown name) shoved her and she fell in the bushes causing scrapes and bruising and the police were called on the scene but she said all she was wanting to do was find out where they sent her mother and why they couldn't get what (Facility #7) needed to admit her mother where she wanted her to go. She said that was when the SSD pushed out the cracked door a post-it-note with (Facility #4) Administrator name and their phone number on it. She said she called (Facility #4) and spoke to the Administrator who was very nice and accommodating and even took his phone to her mother so she could be assured that she was alright. b. On 3/27/2020 at 1:32 PM, Resident #1 was asked via phone interview if she was upset about having to move to another facility. She said, At first I was upset. She was asked if she was given a choice to stay if she wanted to and was also asked if not, was she given a choice of where she wanted to go. She said, No, I was not given an option to stay and no option to go where I wanted to go. c. On 4/2/2020 Resident #1 daughter was interviewed via phone and was asked if her mother received all her personal belongings when she moved. She said, No, her hearing aid and glasses did not go with her. I didn't know that they were not sent with her until (Facility #1) called me to come pick them up the following Monday (3/23/20). I took them to her after I picked them up on Monday. She went from Thursday (3/19/20) until Monday without her hearing aids and her glasses, a total of 4 days. 2. Resident #2 had [DIAGNOSES REDACTED]. She was admitted on [DATE]. The Quarterly MDS with an ARD of 2/28/20 documented a BIMS score of 13 (13 - 15 indicates cognitively intact). a. On 3/27/2020 at 10:38 AM, Resident #2 was asked via phone interview if she was upset about the move and being discharged to the other facility after 11:00 PM Thursday night. She said, I don't understand why all of us had to move over here. They could have put those people somewhere else. I got moved over her about midnight. I was the last one left in the building at (Facility #1). They said we were being moved because they were going to use that building for the sick people. That new flu going around. They said everybody had to move but we could move back when this was over. I told them they would have to sterilize the building before I'll come back. 3. Resident #3 had [DIAGNOSES REDACTED]. She was admitted on [DATE]. The Annual MDS with an ARD of 12/25/19 documented a BIMS score of 14 (13-15 indicates cognitively intact). a. On 3/27/2020 at 10:50 AM, Resident #3 was asked via phone interview if she was upset about having to move, if they told her why she was having to move, if they gave her the option of staying and if not was she given a choice of where she wanted to go. She said, We were not given an option to stay. We were told they were closing the Nursing Home down and they were turning it into a Coronavirus home, and we couldn't stay. 4. Resident #4 had [DIAGNOSES REDACTED]. She was admitted on [DATE]. The Quarterly MDS with an ARD of 2/3/20 documented a BIMS score of 15 (13-15 indicates cognitively intact). a. On 3/27/2020 at 11:20 AM, Resident #4 was asked via phone interview if she was upset about the move, was she given an option to stay, if not, was she given a choice of where

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	045259	A. BUILDING _____ B. WING _____	**04/06/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
THE WATERS OF WOODLAND HILLS, LLC	**8701 RILEY DRIVE LITTLE ROCK, AR 72205**

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 0600

Level of harm - Actual harm

Residents Affected - Some

(continued... from page 6)

she wanted to go and if they gave her a reason for making her move. She stated, They told us we had to move because of the coronavirus they were putting people over there with [MEDICAL CONDITION] and I didn't want us to get it; so, I chose to move and not risk getting it. 5. Resident #5 had a [DIAGNOSES REDACTED]. He was admitted on [DATE]. The Quarterly MDS with an ARD of 1/24/20 documented a BIMS score of 15 (13-15 indicates cognitively intact). a. On 3/27/2020 at 11:14 AM, Resident #5 was asked via phone interview if he was upset about having to move, was he given a reason for the move, was given an option to stay and if not was he give a choice of where he wanted to move to. He stated, I was upset about having to move because it came so sudden; no time to prepare for it. I was not given an option; I was told I had to move. They told me it was because of the coronavirus. They were going to use if for people who had [MEDICAL CONDITION]. I was not given a choice of where to move. 6. Resident #6 had [DIAGNOSES REDACTED]. He was admitted on [DATE]. The Significant Change in Status MDS with an ARD of 1/30/20 documented a BIMS score of 15 (13-15 indicates cognitively intact). a. On 3/27/2020 at 11:14 AM, Resident #6 was asked via phone interview if he was upset about the move, was he given a reason for the move, was he given an option to stay and if not, was he given the choice of where he wanted to move to. He said, I was told the night before that I would be moving the next morning around 9 AM. I left actually about 11 - 12. They said the Federal Government was taking the building over and if you had the coronavirus you would go there. They told us that they were told at the last minute and that was the reason for such short notice. I was not given the option to stay and I had a best friend in there, but they split us up. They sent him to (Facility #4) and I'm here (Facility #2). 7. Resident #7 had [DIAGNOSES REDACTED]. He was admitted on [DATE]. The Quarterly MDS with an ARD of 12/19/19 documented a BIMS score of 14 (13-15 indicates cognitively intact). a. On 3/27/20 at 2:40 PM, Resident #7) was asked via a phone interview if he was upset about the move, what he was told the reason he was having to move, if he was given an option to stay and if not, was he given a choice of where he wanted to go. He said, When I first was told I had to move, I was upset about moving. They did not notify my family; I did but by the time I notified my family I had already been moved. b. On 4/1/2020 at 3:49 PM, Resident #7 family was interviewed via phone and she was asked if she was notified prior to his move and if so when, if she was told why he had to move, if he was given an option of staying and if not, was he given a choice where he wanted to go. She said, No ma'am, I was not notified. I called him that Wednesday morning and asked if he was getting his baths. He said he was going downtown, and I said downtown where, and I told him to hang up and I was calling up there to see what was going on. I called facility and spoke with the DON (Director of Nursing) and she told me they were moving him to (Facility #6). He was there before going to (Facility #1). She told me they were moving everybody out because getting corona (coronavirus) patients. She said it was such a short notice; nobody knew anything. I was very upset about this. I would have took it better if we had gotten a letter or something and some time so we could better adjust. I don't think (Resident #7) was too happy about leaving. If they had notified me and let me know beforehand, I could have found a place that I wanted him to go. I was given no type of choice; none of us were. When I got his things, I found a paper stuck inside one of the bags that said residents names; where they were going and what time they were going. They called me Friday morning and told me I had to get his things that day. They said there were getting patients with [MEDICAL CONDITION] on Monday. She also said that (Resident #7) wasn't given a chance; no one was given a chance to stay. 8. Resident #9 had [DIAGNOSES REDACTED]. She was admitted on [DATE]. The Admission MDS with an ARD of 2/12/20 documented a BIMS score of 2 (0-7 indicates severe cognitively impaired). a. On 4/1/2020 at 4:20 PM, a Friend/Responsible Party of Resident #9 was interviewed via phone and was asked if she was notified prior to her being discharged , if she was given a reason for the discharge, if she was given an option of her staying and if not, was she given a choice of where she wanted to go and if she was upset about having to move. She said, I'm not sure who called me or when they called; it sounded like a male. I was told that the Nursing Home was going to be used to house the COVID-19 patients. (Resident #9) has been completely abandoned by her family and I'm all she has now. We've been friends for about [AGE] years now. She had a stroke in December, and she has been crying since then. Since I've not been able to visit her with all this going on, I don't know if this has worsened or not. 9. Resident #11 had [DIAGNOSES REDACTED]. She was admitted on [DATE]. The Annual MDS with an ARD of 2/7/20 documented a BIMS score of 15 (13-15 indicates cognitively intact). a. On 3/27/2020 at 4:02 PM, Resident #11 was interviewed via phone and was asked if she was upset about having to move, was she given a reason for the move, was she given an option to stay and if not, was she given a choice of where she wanted to go. She said, I was upset at first. They told me they were closing down because they were going to be taking care of people with [MEDICAL CONDITION]. She said that she wasn't given an option to stay because they told us everybody had to leave. She also said she was not given a choice of where she wanted to go either. 10. Resident #12 had [DIAGNOSES REDACTED]. She was admitted on [DATE]. The significant change MDS with an ARD of 1/4/20 documented a BIMS score of 15 (13-15 indicates cognitively intact). a. On 3/21/2020 at 3:15 PM, Resident #12 was interviewed via phone and was asked if she was upset about having to move, was she given a reason for the move, was she given an option to stay and if not, was she given a choice of where she wanted to go. She said, Yes, I was told about the move, but they let us know the night before. They told us it was because of the [MEDICAL CONDITION] and they were going to start taking people in. I was upset they were going to use that place as a quarantine area. I didn't get an option to stay or where I wanted to go. 11. Resident #13 had [DIAGNOSES REDACTED]. He was admitted on [DATE]. The significant change MDS with an ARD of 1/25/20 documented a BIMS score of 9 (8-12 indicates moderate cognitive impairment). a. On 4/1/20 at 3:36 PM, Resident #13 was interviewed via phone and he was asked if he was upset about having to move, was he given a reason for the move, was he given an option to stay and if not, was he given a choice of where he wanted to go. He said, I was upset because I had to move. They didn't tell me why I was moving; they just came and told me I had to move, and I was moved that day. b. On 4/1/20 at 3:11 PM, Resident #13's family was interviewed via phone and she was asked if he was upset about having to move, was she notified prior to him moving, was she told the reason for him moving, was he given the option to stay and if not was he given a choice on where to go. She said, Someone from there called me and told me they were moving him to (Facility #2). I can't remember when they called me though. I haven't talked to him since the transfer. They told me that (Facility #1) was a COVID facility and that's why they were notifying people. I wasn't upset because of the reason they were moving him. I knew they couldn't be there with COVID people. 12. Resident #14 had [DIAGNOSES REDACTED]. He was admitted on [DATE]. The Quarterly MDS with an ARD of 2/19/20 documented a BIMS score of 15 (13-15 indicates cognitively intact). a. On 3/27/20 at 3:22 PM, Resident #14 was interviewed via phone and he was asked if he was upset about having to move, was he notified prior to him moving, was he told the reason for him moving, was he given the option to stay and if not, was he given a choice on where to go. He said, My memory is not all that great . I want to say yes, I had a great deal of anxiety when they first told me, and it was rather abrupt, and it was a major stressor. I do remember being a little upset; wasn't to the point that I acted out or anything. I wished more time could have been allotted. The way we moved was like, Hey, pack it up, we got to leave. I was not given an option to stay. To my knowledge no one was given an option to stay. 13. Resident #15 had [DIAGNOSES REDACTED]. The Quarterly MDS with an ARD of 3/15/20 documented a BIMS score of 15 (13-15 indicates cognitively intact). a. On 3/27/20 at 3:06 PM, Resident #15 was interviewed via phone and he was asked if he was upset about having to move, was he notified prior to him moving, was he told the reason for him moving, was he given the option to stay and if not was he given a choice on where to go. He said, They told me I was moving because of the overflow from the hospital to make room for people coming from the hospital. Sure, I was upset; they told me I had to move. I wasn't given an option, they said they needed the beds. I was upset, I didn't know what place they were sending me. 14. Resident #16 had [DIAGNOSES REDACTED]. He was admitted on [DATE]. The Quarterly MDS with an ARD of 2/15/20 documented a BIMS score of 15 (13-15 indicates cognitively intact). a. On 4/1/20 at 12:43 PM, Resident #16 was interviewed via phone and he was asked if he was upset about having to move, was he notified prior to him moving, was he told the reason for him moving, was he given the option to stay and if not was he given a choice on where to go. He said, I wasn't upset about it, but they didn't give me a notice. I found out I was being moved about 10 minutes prior to the move. II. Non-Sample Selected Resident Interviews: 1. On 3/27/20 at 2:20 PM, an interview was conducted via phone with a Non-Sample Selected Resident and was asked if she was upset about the move, told the reason for the move, was given an option to stay and if not was given a choice of where they wanted to go. She stated, My sugar had dropped to 31. They (Facility #1) sent me out to (Hospital #1). I stayed there until I was stable; about 3 days, then I was sent to (Facility #6). I thought I was going back to (Facility #1) but they sent me here (Facility #6). I don't know why they sent me here. I think they called my momma after they got me here. I told them (Facility #6) I wanted to talk to my momma because my phone was dead since I didn't have my phone charger with me. After I got my phone charger and charged my phone, I called my momma and told her where I was at. a. At 2:33 PM, I spoke with (Facility #6) Administrator and asked him if and when he notified the above Resident's momma that she was sent here; not (Facility #1). He said, I talked to her mother the day she got here. They (Facility #1) had not told her that she would not be going back there. 2. On 3/27/20 at 2:32 PM, an interview was conducted via phone with a Non-Sample Selected

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045259	A. BUILDING _____ B. WING _____	04/06/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
THE WATERS OF WOODLAND HILLS, LLC	8701 RILEY DRIVE LITTLE ROCK, AR 72205

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 0600 **Level of harm -** Actual harm **Residents Affected -** Some	(continued... from page 7) Resident and was asked if she was upset about the move, told the reason for the move, was given an option to stay and if not was given a choice of where they wanted to go. She said, I was not told reason I was moving, and I was not given a choice on where I was moving too and no one came and told me I was going to be moving before they moved me. 3. On 3/27/20 at 2:37 PM, an interview was conducted via phone with a Non-Sample Selected Resident and was asked if she was upset about the move, told the reason for the move, was given an option to stay and if not was given a choice of where they wanted to go. He said, I was not given an option to stay. No, no reason given either; just told me we had to move. No, not given any options. 4. On 3/27/20 at 3:50 PM, an interview was conducted via phone with a Non-Sample Selected Resident and was asked if he was upset about the move, told the reason for the move, was given an option to stay and if not was given a choice of where they wanted to go. He said, I don't think they gave me an option to stay. They told us it was because of the flu. 5. On 3/27/20 at 4:44 PM, an interview was conducted via phone with a Non-Sample Selected Resident and was asked if he was upset about the move, told the reason for the move, was given an option to stay and if not was given a choice of where they wanted to go. He said, I was not given a reason for moving. I was upset about having to move. I was not given an option to stay. I was not given a choice of what facility I wanted to go to. 6. On 3/27/20 at 4:46 PM, an interview was conducted via phone with a Non-Sample Selected Resident and was asked if he was upset about the move, told the reason for the move, was given an option to stay and if not was given a choice of where they wanted to go. She said, I was not given an option to stay. I was not given a choice of what facility I wanted to go to. I was upset about moving because they did it all in one day. The (Certified Nurse Assistant) CNA's told me as they were moving me it was because they were going to be moving peoples with the [MEDICAL CONDITION] in there. 7. On 3/27/20 at 5:05 PM, an interview was conducted via phone with a Non-Sample Selected Resident and was asked if he was upset about the move, told the reason for the move, was given an option to stay and if not was given a choice of where they wanted to go. She said, I was not given an option to stay and I don't think I was given a choice of where I wanted to go. Yes, I was upset about moving. You get in a routine and get secure with it and it gets pulled out from under you. They said I was having to move because they were putting the COVID-19 in there. They told me I was having to move, and they moved me the next day. III. Non-Sampled Resident Family Interviews 1. On 3/27/20 at 2:20 PM, an interview was conducted via phone with a Non-Sample Selected Resident and was asked if she was upset about the move, told the reason for the move, was given an option to stay and if not, was she given a choice of where they wanted to go. She stated, My sugar had dropped to 31. They (Facility #1) sent me out to (Hospital #1). I stayed there until I was stable; about 3 days, then I was sent to (Facility #6). I thought I was going back to (Facility #1) but they sent me here (Facility #6). I don't know why they sent me here. I think they called my momma after they got me here. I told them (Facility #6) I wanted to talk to my momma because my phone was dead since I didn't have my phone charger with me. After I got my phone charger and charged my phone, I called my momma and told her where I was at. a. At 2:33 PM, surveyor spoke with (Facility #6) Administrator and asked him if and when he notified the above Resident's momma that she was sent here; and not (Facility #1). He said, I talked to her mother the day she got here. They (Facility #1) had not told her that she would not be going back there. 2. On 3/27/20 at 2:32 PM, an interview was conducted via phone with a Non-Sample Selected Resident and was asked if she was upset about the move, told the reason for the move, was given an option to stay and if not, was she given a choice of where they wanted to go. She said, I was not told reason I was moving, and I was not given a choice on where I was moving too, and no one came and told me I was going to be moving before they moved me. 3. On 3/27/20 at 2:37 PM, an interview was conducted via phone with a Non-Sample Selected Resident and was asked if she was upset about the move, told the reason for the move, was given an option to stay and if not, was he given a choice of where they wanted to go. He said, I was not given an option to stay. No, no reason given either; just told me we had to move. No, not given any options. 4. On 3/27/20 at 3:50 PM, an interview was conducted via phone with a Non-Sample Selected Resident and was asked if he was upset about the move, told the reason for the move, was given an option to stay and if not, was he given a choice of where they wanted to go. He said, I don't think they gave me an option to stay. They told us it was because of the flu. 5. On 3/27/20 at 4:44 PM, an interview was conducted via phone with a Non-Sample Selected Resident and was asked if he was upset about the move, told the reason for the move, was given an option to stay and if not, was given a choice of where they wanted to go. He said, I was not given a reason for moving. I was upset about having to move. I was not given an option to stay. I was not given a choice of what facility I wanted to go to. 6. On 3/27/20 at 4:46 PM, an interview was conducted via phone with a Non-Sample Selected Resident and was asked if he was upset about the move, told the reason for the move, was given an option to stay and if not, was she given a choice of where they wanted to go. She said, I was not given an option to stay. I was not given a choice of what facility I wanted to go to. I was upset about moving because they did it all in one day. The (Certified Nurse Assistant) CNAs told me as they were moving me it was because they were going to be moving peoples with the coronavirus in there. 7. On 3/27/20 at 5:05 PM, an interview was conducted via phone with a Non-Sample Selected Resident and was asked if he was upset about the move, told the reason for the move, was given an option to stay and if not was given a choice of where they wanted to go. She said, I was not given an option to stay and I don't think I was given a choice of where I wanted to go. Yes, I was upset about moving. You get in a routine and get secure with it and it gets pulled out from under you. They said I was having to move because they were putting the COVID-19 in there. They told me I was having to move, and they moved me the next day. III. Observations On 3/31/2020 multiple snap shots of the video footage on 3/18/20 and 3/19/20 were received by (Employee #1) via email. They included pictures of multiple large contractor trash bags and plastic and cardboard boxes full of Resident personal belongings piled on top of wheelchairs, serving carts, tables and floor. There were also pictures of clusters of various non-bagged or non-boxed unidentifiable items. Amongst the clutter were some pictures of residents in wheelchairs and/or chairs as well as multiple staff members; including the Maintenance Director. (Photos are available for further details) IV. Corporate and Facility Staff Interviews: a. On 3/20/2020 at 5:16 PM, the Director of the Office of Long-Term Care (OLTC) conducted a phone interview with the Regional Director of (Corporation). She asked what was going on at their (Facility in Little Rock). The State Office had received a general complaint from a family member and the caller informed our office that this facility had transferred all the residents out because of COVID. The Regional Director replied that 53 of 54 were transferred out and the DMS (Division of Medical Service) 702's (Notice of Admission, Discharge, or Transfer from a facility) were completed yesterday. There isn't any COVID. She stated the residents were sent to the sister facilities within 3 days except for 4 families that requested other placements. She stated that they are doing deep cleaning on the facility, will have 1 hall for positive COVID and another hall for presumptive COVID. The Director OLTC made the statement that it would have been a good idea for them to notify the OLTC in advance as to their plan. The Regional Director said that the Corporation wanted to get out in front of this COVID and that they had implemented this in the other stated where they own Nursing Homes. c. On 3/24/2020 at 3:50 PM, spoke to the Administrator via phone and asked her what transpired at her facility last week with discharging all of their residents. She said, I have already spoken to (Director of the OLTC) today but proceeded telling me that last Tuesday (3/17/20) the Regional Director called the DON (Director of Nursing) and herself into her office and proceeded to instruct them to start moving all residents out of the building starting Wednesday (3/18/20) and the building needed to be empty by Friday (3/20/20). She said that the building was going to be a dedicated COVID-19 reception facility and then she assembled all the Department Heads and re-iterated what she had already told her and her DON. On Wednesday at 9:00 AM (Regional Director) and the (Nurse Consultant) came to the facility and began staging people for relocation to sister facilities in Little Rock. Residents were matched with the sister facilities in Little Rock based on their needs. She said the first resident was transferred out on that Wednesday and the last one was sent out by that Thursday night around 11:45 PM. She said on that Friday and over the weekend residents' remaining personal items were taken to their locations. She was asked if the residents were screened for COVID19 before transferring them. She said that their vital signs were taken, and thorough assessments and they did not have any signs/symptoms of COVID-19. She was asked if the residents and/or their Responsible Party were given a choice on their relocation. She said, They were not given a choice on their relocation at first. She said the DON assigned each to go to one of their sister facilities and if a resident and/or their Responsibility Party didn't agree with the facility chosen she accommodated every single alternate request. She went on to say that in doing that she was written up by (Regional Director) for doing that. She said I did not follow process previously discussed prior to the discharges and since 3/17/20 discharges kept changing. She also said that (Regional Director) was present during several irate family member telephone calls demanding alternate facility be arranged and also overheard her conversation with the Ombudsman on the issue and at that point she had no input at all until yesterday when I was written up for not following her directive prior to discharging residents to their sister facilities. She was asked if there were any residents' family upset about having to go to one of their sister facilities if their alternate request was not honored. She said, There was one daughter that

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	045259	A. BUILDING _____ B. WING _____	04/06/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
THE WATERS OF WOODLAND HILLS, LLC	8701 RILEY DRIVE LITTLE ROCK, AR 72205

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 0600 **Level of harm** - Actual harm **Residents Affected** - Some	(continued... from page 8) wanted her mother to go to (Facility #7) but the SSD spoke with the Admission Coordinator at (Facility #7) on the 19th. They finally told her they would not accept her mother and they did not give a reason. Resident #1 was the 3rd to the last resident transferred and we had no choice but to send her to (Facility #4) due to needing to get everyone out that day. She was asked who and when her staff started notifying residents and/or their families about the move. She said, We set up Guardian Angel rounds for each hall and they were the ones that began notifying resident and/or their families She was asked why the residents and/or their families were not given sufficient written notice of their impending discharge. She said, I was following my superiors' directives. d. On 3/25/2020 at 8:09 AM, placed call to (Regional Director) and asked her what her involvement was in reference to the Resident Mass Discharge from (Facility #1) last week. She said, I was there and helped coordinate which facility residents wanted to go to our Sister Facilities which include: (Facility #6), (Facility #2), (Facility #4) and (Facility #3). She went on to say that there were 4 or 6 who chose to go to other locations that were not one of their sister facilities. She was asked if the residents and/or their Responsible Parties were given a notice and reason for the discharge in writing and if so, how long of a notice did they give them. She said, The staff called them on Tuesday and Wednesday of last week; gave them information over the phone and backed it up in writing that was given to the residents and their Responsible Parties could get a copy of it if they wanted. They were told that they would be having patients come in that were at risk for COVID-19. They were not told that they wo
F 0684 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide appropriate treatment and care according to orders, resident's preferences and goals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure arrangements were made for the continued provision of continuous positive airway pressure ([MEDICAL CONDITION]) upon transfer and / or discharge of a resident with [DIAGNOSES REDACTED].#2) of 1 sampled resident who was transferred / discharged to another facility. This failed practice had the potential to affect 2 residents who required [MEDICAL CONDITION] therapy, per a list provided by the Director of Nursing (DON) on 4/2/2020 at 4:24 p.m. The findings are: Resident #2 had [DIAGNOSES REDACTED]. The Quarterly Minimum Data Set (MDS) with an Assessment Reference Date of 2/28/2020 documented the resident scored 13 (13-15 indicates cognitively intact) on a Brief Interview for Mental Status; experienced shortness of breath with exertion; and required oxygen. a. The Care Plan dated 4/8/19 documented, (Resident #2) has [MEDICAL CONDITIONS] .[MEDICAL CONDITION] as per order . May fill [MEDICAL CONDITION] with ice . b. On 4/3/2020 at 11:19 a.m., Licensed Practical Nurse (LPN) #1 was notified via telephone at Facility #2 (the receiving facility) and was asked if (Resident #2) had been transferred to her facility with a [MEDICAL CONDITION]. She stated, She (the resident) did not come here with her [MEDICAL CONDITION]. She mentioned it to me yesterday. I didn't know anything about it. We told the doctor's nurse. c. On 4/3/2020 at 11:29 a.m., the Administrator at Facility #1 (the transferring facility) was notified via telephone and was asked about (Resident #2's) [MEDICAL CONDITION], and if it had been delivered to the receiving facility. She stated, I will have to check on this. d. On 4/3/2020 at 1:29 p.m., the Administrator notified the surveyor via telephone and stated, I was told that we couldn't transport the [MEDICAL CONDITION]. (Durable Medical Company (DME) Company) has picked it up. I'm waiting on a call from them. e. On 4/10/2020 at 9:24 a.m., Resident #2 was notified via telephone and was asked if she was sent (transferred / discharged) with her [MEDICAL CONDITION] when she was transferred. She stated, I was not sent with my [MEDICAL CONDITION] when I came over here (to Facility #2). I still don't have my [MEDICAL CONDITION]. I used it when they changed me. I just use oxygen now. I used it at night, but not every night.
F 0835 **Level of harm** - Actual harm **Residents Affected** - Some	**Administer the facility in a manner that enables it to use its resources effectively and efficiently.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews the facility's Administration failed to ensure residents/ residents representatives received greater than a 24-hour notice before residents were quickly transferred to other nursing facilities to prevent mental anguish and anxiety for all 64 residents transferred on [DATE] and [DATE]. This failed practice affected all 64 residents in the facility per lists provided by the Regional Director on [DATE] between 11:34 AM and 3:34 PM via emails. The findings are: I. Corporate and Administration Interviews: a. On [DATE] at 5:16 PM, the Director of the Office of Long-Term Care (OLTC) conducted a phone interview with the Regional Director of (Corporation). She asked what was going on at the (Facility in Little Rock). The State Office had received a general complaint from a family member and the caller informed our office that this facility had transferred all the residents out because of COVID. The Regional Director replied that 53 of 54 were transferred out and the DMS (Division of Medical Service) 702's (Notice of Admission, Discharge, or Transfer from a facility) were completed yesterday. There isn't any COVID. She stated the residents were sent to the sister facilities within 3 days except for 4 families that requested other placements. She stated that they are doing deep cleaning on the facility, will have 1 hall for positive COVID and another hall for presumptive COVID. The Director OLTC made the statement that it would have been a good idea for them to notify the OLTC in advance as to their plan. The Regional Director said that the Corporation wanted to get out in front of this COVID and that they had implemented this in the other stated where they own Nursing Homes. b. On [DATE] at 3:22 PM, spoke with Resident #1's daughter and was asked if she was aware of the reason for her mother's discharge from the facility and when she was notified of her impending discharge and if she was given a choice of which facility she wanted her mother to be discharged to and if she was given an option of her mother staying at the facility and not being discharged . She stated, I found out initially from mother's (Attending Physician #1's) (Advanced Practice Nurse) that the facility where my mother has been for approximately [AGE] years was discharging all of their residents out by the following Monday to their sister facilities. She knew I wanted my mother to go to (Facility #7) so she was nice enough to call me and give me a heads up. She also said she didn't hear from the facility about this until approximately around 10:30 - 11:00 AM on the 19th that they needed approval from (Facility #7) in 5 minutes if they were going to admit her mother or not. She said she immediately called (Facility #7) and told them that (Facility #1) was ready to transfer her mother right then. They (Facility #7) initially told me that all they needed from (Facility #1) was a Pre-Admission Screening Resident Review (PASRR). She said she then attempted to call (Facility #1) back and never got an answer nor did it ring or give her a busy signal. It would just immediately after dialing just drop the call. She said that was when she called (Facility #7) back and told them of the situation and they told me I'd need to go there and come back to complete admission paperwork and give a deposit to hold the room. She said she immediately went to (Facility #7). Said it was approximately 45 minutes after she spoke to them and while she was there completing paperwork, she got another call from (APRN) and asked what was going on at (Facility #1) because they couldn't get anyone there to answer the phone either. She said she then told the lady at (Facility #7) that she needed to go to (Facility #1) and see what was going on. She said she got there around 3:00 PM and her mother was already gone. She asked where they (Facility #1) sent her and they told her (Facility #7) and that's when she became irate and told them No .you didn't send her there (Facility #7) .I just came from there!!! And was screaming at them, Where is my mother? over and over when they finally told her that they had sent her to (Facility #4) since (Facility #7) would not accept her mother. She said she told them that (Facility #7) and herself had been trying to get in touch with them all day to tell them they just needed a (PSARR) and that was when the Administrator and the SSD (Social Service Director) told her no, they had been in contact with (Facility #7) multiple times throughout the day and the conversation became very heated at that point to the point a male (unknown name) shoved her and she fell in the bushes causing scrapes and bruising and the police were called on the scene but she said all she was wanting to do was find out where they sent her mother and why they couldn't get what (Facility #7) needed to admit her mother where she wanted her to go. She said that was when the SSD pushed out the cracked door a post-it-note with (Facility #4) Administrator name and their phone number on it. She said she called (Facility #4) and spoke to the Administrator who was very nice and accommodating and even took his phone to her mother so she could be assured that she was alright. c. On [DATE] at 3:50 PM, spoke to the Administrator via phone and asked her what transpired at her facility last week with discharging all of their residents. She said, I have already spoken to (Director of the OLTC) today but proceeded telling me that last Tuesday ([DATE]) the Regional Director called the DON (Director of Nursing) and herself into her office and proceeded to instruct them to start moving all residents out of the building starting Wednesday ([DATE]) and the building needed to be empty by Friday ([DATE]). She said that the building was going to be a

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F 0835 **Level of harm -** Actual harm **Residents Affected -** Some	(continued... from page 9) dedicated COVid-19 reception facility and then she assembled all the Department Heads and re-iterated what she had already told her and her DON. On Wednesday at 9:00 AM (Regional Director) and the (Nurse Consultant) came to the facility and began staging people for relocation to sister facilities in Little Rock. Residents were matched with the sister facilities in Little Rock based on their needs. She said the first resident was transferred out on that Wednesday and the last one was sent out by that Thursday night around 11:45 PM. She said on that Friday and over the weekend residents' remaining personal items were taken to their locations. She was asked if the residents were screened for COVID-19 before transferring them. She said that their vital signs were taken, and thorough assessments and they did not have any signs/symptoms of COVID-19. She was asked if the residents and/or their Responsible Party were given a choice on their relocation. She said, They were not given a choice on their relocation at first. She said the DON assigned each to go to one of their sister facilities and if a resident and/or their Responsibility Party didn't agree with the facility chosen she accommodated every single alternate request. She went on to say that in doing that she was written up by (Regional Director) for doing that. She said I did not follow process previously discussed prior to the discharges and since [DATE] discharges kept changing. She also said that (Regional Director) was present during several irate family member telephone calls demanding alternate facility be arranged and also overheard her conversation with the Ombudsman on the issue and at that point she had no input at all until yesterday when I was written up for not following her directive prior to discharging residents to their sister facilities. She was asked if there were any residents' family upset about having to go to one of their sister facilities if their alternate request was not honored. She said, There was one daughter that wanted her mother to go to (Facility #7) but the SSD spoke with the Admission Coordinator at (Facility #7) on the 19th. They finally told her they would not accept her mother and they did not give a reason. Resident #1 was the 3rd to the last resident transferred and we had no choice but to send her to (Facility #4) due to needing to get everyone out that day. She was asked who and when her staff started notifying residents and/or their families about the move. She said, We set up Guardian Angel rounds for each hall and they were the ones that began notifying resident and/or their families She was asked why the residents and/or their families were not given sufficient written notice of their impending discharge. She said, I was following my superiors' directives. d. On [DATE] at 8:09 AM, placed call to (Regional Director) and asked her what her involvement was in reference to the Resident Mass Discharge from (Facility #1) last week. She said, I was there and helped coordinate which facility residents wanted to go to our Sister Facilities which include: (Facility #6), (Facility #2), (Facility #4) and (Facility #3). She went on to say that there were 4 or 6 who chose to go to other locations that were not one of their sister facilities. She was asked if the residents and/or their Responsible Parties were given a notice and reason for the discharge in writing and if so, how long of a notice did they give them. She said, The staff called them on Tuesday and Wednesday of last week; gave them information over the phone and backed it up in writing that was given to the residents and their Responsible Parties could get a copy of it if they wanted. They were told that they would be having patients come in that were at risk for COVID-19. They were not told that they would admitting patients with COVID-19 because the CDC (Centers for Disease Control) guidelines won't let them admit with a positive COVid19 and currently they have patients from other facilities at the hospital with fever, pneumonia, respiratory issues and if they weren't from one of our facilities we can't admit any of them at this time. She was asked what the urgency was and why they were not given a 30-day written notice. She said, We didn't give them a 30-day notice because none of them were forced to leave and they were all given the option to stay. She said they all decided to go to other facilities and were assured once they got stabilized, they could come back if they wanted to. She went on to say that they had done this same thing in other states, Tennessee, Illinois, Indiana and Kentucky without any issues. She was asked if the Medical Director or the Residents Attending Physicians were involved in this decision. She said, (Medical Director) and his partner were involved via phone and she had bumped into them on a couple of occasions and they were both on board with their decision. She was asked if any of them documented in the Residents Medical Record the reason for the discharges and reason they could not continue to meet their needs. She said, We have not to my knowledge documented such in any of the Residents Medical Records. She was asked if a Discharge Summary was done on each Resident discharged . She said, I think they are working on that now. She was asked how the receiving facilities were made aware of each Residents Medical Care while at their facility along with the medications/treatments/care and condition at time of discharge to ensure continuity of care. She said, Each resident went to their designated facilities with a paper packet including their MARS, (Medication Administration Records) TARS, (Treatment Administration Records) orders and anything else relevant and that their medications went with them and each of them had an armband attached to them with pertinent information. She said the nurses delivered their Narcotics. She was asked if she was aware of any families that were upset because their loved one were not allowed to go to a facility that was not one of their sister facilities. She said, There was one family that was upset because the facility she wanted her mother to go to would not accept her mother. e. On [DATE] at 11:55 AM, the Social Service Director (SSD) was asked via phone what her involvement was in reference to the mass resident discharge that occurred at her facility last week. She said, (Regional Director) came in on the 17th and informed the Dept. Heads that they were going to be a COVID-19 building taking in patients that had been tested positive and were presumptive positive with it as well. We started calling families that day informing them of what she told us to say and to let them know they were going to send them to their sister facilities or to facilities of their choosing. She told us we had to have them all out of there by the 20th. She was asked if she knew why they were given this decision with such a short notice. She said, No, we weren't told why it had to be done in such a short time frame. She was asked if they were given the option to stay at the facility if they did not wish to be sent elsewhere. She said, They were not given that option but there was little resistance; just confusion since they thought by what we told them we already had or would shortly be having residents with COVID-19. She went on to say that they were not forced to leave but they did not want to stay if we were going to admit residents with COVID-19. She was asked if they gave any of the residents and/or their families' written notice. She said, We did not put anything in writing because they were just told to call and inform them of what we were to tell them. She started sending residents out on the 18th and the last one was sent out at 11:45 PM, the night of the 19th. She was asked when and who informed Resident #1 family of the plan to send her mother to one of your sister facilities. She said, I contacted her daughter on the 17th. She was asked if Resident #1 daughter told them that she did not want her mother to go to one of their sister facilities' but wanted her to go elsewhere. She said, She did tell us she wanted her mother to go to (Facility #7) but they would not accept her for whatever reason, so we had to send her to our sister facility; (Facility #4). She was asked if this was all documented. She said, Yes, it was, and I could have access to it per PCC (personal computer chart).She was asked why they told the residents and/or their families that you were going to admit COVID-19 residents when I was told by (Regional Director) earlier that day that you would not be admitting COVID-19 residents due to CDC guidelines their facility could not admit anyone with COVID-19 or Presumptive positive for COVID-19. She said, That had changed since they were first told what they had plans to do and that now they would not be doing what they had told the residents and/or their families the other day. She was asked after they decided not to admit COVID-19 residents did they notify the residents and/or their families to see if they may want to come back. She said, No. f. On [DATE] at 5:46 PM, surveyors entered the facility. The DON was on staff and there was a new admit just a few minutes prior to surveyors arriving. Shortly after entering the facility the DON received a call from the Administrator and after they spoke for a few minutes the Administrator asked to speak to the surveyor. She wanted to know if she needed to come to the facility and she was informed that wasn't necessary and her interview could be conducted over the phone. The Administrator was asked if the Medical Director was involved with the Corporate decision to transfer all the residents and she said, he wasn't informed until it was already happening, and he was upset. The DON was asked if she had anything in writing as to what type of admit she could take and how to care for them, she said she was told that (Facility #1) would admit residents with Upper Respiratory Infections and they would be on the right side of the building and then after 14 days they could go back to the (Corporate Facilities) that they came from but if they want to stay they would be moved to the left side of the building. She was asked if the care of these residents would be any different such as increased monitoring for temperature and O2 (oxygen) saturations and she stated, Yes. The DON looked on her cell phone for an email with instructions from Corporate and said she was sure she had something but was unable to find it right away. She stated she would email it to the surveyors when she found it. At 5:52 PM, the DON was asked what the urgency was to get the residents out and she stated, Corporate came and met with us on that Tuesday and gave us instructions that we were going to be a COVID-19 facility and we were to get all of our current residents discharged by Friday of that week. At the time of the visit the DON was unable to locate any guidance from the facility. The DON was asked to email what guidance she had received on how to care for the residents being admitted . g. On [DATE] at 7:39 PM, an email was received from the DON and it stated, .spoke with (Nurse Consultant) and (Regional Director) and they will be getting me documentation on how the

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F 0835 **Level of harm -** Actual harm **Residents Affected -** Some	(continued... from page 10) decisions with the Admission Process was made. h. On [DATE] at 8:45 AM, called the Ombudsman to ask her what she knew about all (Facility #1) residents being discharged out of their facility last week and if she had received any complaints from anyone about that. She said, I became aware of what they were doing when the Administrator called me on [DATE] to inform me that they would be discharging all of their current residents to sister facilities because they were going to be a Positive COVID-19 only building and that they would start admitting these patients type of residents from their Sister Facilities. She said she thought that our office (OLTC) had asked them to do this. She said the only Complaints she had received were from one family member of Resident #7 that they had not been informed of his move until a family member of another resident told them about it the day after he was moved. She said she called the Administrator after receiving this complaint and was told by her that her staff had notified all families the day before their resident was moved. She also said that she had received a complaint from an anonymous individual that the facility was throwing away resident belongings. She said she called the Administrator about this also and was told that they had not thrown any of the residents personal items away and in fact was told by a family that they should just toss those things because they didn't want them and if they got thrown away the family had to have done so. She also said the only complaints she received from residents were they didn't understand why their personal belongings weren't being sent with them as they were being sent to other facilities because they were afraid they wouldn't ever get them back. She said she asked the Administrator about this as well and was told that their belongings were taken to the facilities later. That's why I haven't notified the OLTC of all of the complaints I have been receiving surrounding this issue. Like I said, I thought the facility had been in close contact with the OLTC about all of this. i. On [DATE] at 12:10 PM, (Employee #1) called and stated that she was so upset about what happened to their residents that were sent out of their facilities on the 18th and 19th. They were pulled out of their beds and put in their wheelchairs and put out in the hallways lined up like cattle. (Resident #11) was crying and non-sample selected Resident and (Resident #3) were very mad and (Resident #6) was very upset and he went to hospital for [MEDICAL TREATMENT] 3 times a week. Also, (Resident #9) (non-verbal) was so upset she was crying (more than usual), also (Resident #12, #13, #14 and #15) were also upset about the move and (Resident #10) passed away right after the move but I don't know what he died from. j. On [DATE] at 12:45 PM, (Contracted Staff #1) called and reported that he assisted with transporting 8 residents on Wednesday and 4 - 5 residents on Thursday. He said that he had been transporting (Resident #6) previously to [MEDICAL TREATMENT] before he was discharged from that facility. He said that (Resident #6) was appalled and furious about having to move. He also said that since last Thursday all of the residents personal belongings were in trash bags and sitting in the lobby and hallway in front at (Facility #2) which saddened me since so many of these residents that is all they have left to their name and it was tossed about like it was nothing. Seemed as though they weren't thinking or caring about the resident's wellbeing. He went on to say that the only person he currently trusted was the previous Administrator; that they have fired for not lying to us. He said that he was witnessed to families not being told that their loved ones were being moved, patients' belongings in trash bags out in the hallways of (Facility #1) and it appeared that some of the residents whom he transported had not received care before they were sent out. He said that he also heard last Friday the DON and SSD talking about throwing away residents' personal belongings and heard (Nurse Consultant) saying to them We're not taking their things to them and I don't care what you do with them; toss them for all I care. At 1:44 PM, he called back to inform surveyor of the residents he transported and time of transports on the 18th and 19th to (Facility #2). On Wednesday (18th) he gave the following names and times of transport: (Resident #6) at 9:30 AM; (Non-Sampled Selected Resident) at 10:00 AM; (Resident #12) at 11:00 AM; (Resident #4) at 11:30 AM; (Non-Sample Selected Resident) at 12:00 PM; (Non-Sample Selected Resident) at 12:30 PM; (Non-Sample Selected Resident) at 3:00 PM; (Non-Sample Selected Resident) at 4:00 PM. On Thursday (19th) he gave the following names and times of transport: (Resident #14) at 9:30 AM; (Resident #5) at 10:45 AM; (Non-Sample Selected Resident) at 12:30 PM, and (Resident #16) at 2:00 PM. He was asked if he was aware of the last resident being sent out late the night of the 19th. He said, Yes, I can attest to that because they asked me to transport (Resident #2) around 11:00 PM that night but I was already on my way to (out of state) and was not able to do that transfer. k. On [DATE] at 2:00 PM, the DON was called and interviewed by phone. She was asked what her involvement was in the mass discharge of all of their previous residents last Wednesday and Thursday. She said, The (Regional Director) told me and the Administrator that she had received directive from above her that they wanted this facility to be for patients that had gone out to hospitals from sister facilities that went into the hospital with respiratory issues and that we were going to transfer our residents to sister facilities. She was asked why many of the other staff had told the surveyor they were told by Corporate to tell Residents/Families the reason for the discharge was due to facility going to be a COVID-19 facility and were going to start admitting them in the very near future. She said, That was what we were initially told but that has since changed. She was asked after this had changed had they notified their previous residents to give them a choice of returning to the facility. She said, No. She was asked if she knew why the rush was to get their previous residents out with little or no notice. She said, We were told by Corporate on the 17th we had to get them all out by the 20th, but we had them all out by the evening of the 19th. She was asked if they gave the Residents/Families a written discharge notice. She said, There was a letter developed that Tuesday evening on the 17th that was read to the Residents and/or family before sending them out. (I'll send you a copy of it). She said she wasn't sure if they were told they had an option to stay and not be discharged . She was asked if she knew when the first resident was sent out and when the last one was sent out. She said, Our first one was sent out on Wednesday morning around 11:30 AM and the last one was sent out on Thursday around 10:30 PM. She was asked how she ensured that each resident arrived at their designated facilities safely. She said, Unless that facility called to question something about them, she just assumed they arrived safely. She was asked if they discussed moving all of their residents out with their Medical Director and/or Residents Attending Physicians. She said, I'm sure each Physician was contacted prior to their residents going to other facilities by someone here. I'm only certain of (Attending Physician #2) because I spoke with his nurse about all of his residents. She was asked in her professional opinion did she think it was wise they move all their residents to facilities during this pandemic crisis with the COVID-19; since all of us have been told to stay put. She said, I can't give my opinion because I don't have one. l. On [DATE] at 3:19 PM, the Director of the OLTC received a phone call from the Regional Director for (Corporation) who informed that (Regional Personnel #1) would be calling and would be explaining the plans and that she would also provide something in writing regarding how the facility would operate now (post transfer all the residents.) The Regional Director informed that (Regional Personnel #1) was still tweaking this process . m. On [DATE] at 4:11 PM, spoke to LPN #2 via phone. She was asked what her involvement was in the mass discharge of the facility's previous residents on the 18th and 19th. She said, On Tuesday, I believe it was the 17th, (Nurse Consultant) from Corporate came in the building around 9:00 to 10:00 and told all of the Department Heads that we would be moving all of the residents out of this facility within the next 2 days because we are going to be a designated COVID-19 facility. We were given a typed message of what we were to tell the Residents/Families. They should be able to get you a copy of that letter. They also had a list of the residents and where they were going to be transferred to so we could get them lined up awaiting transfer to the various facilities. We all had a certain hall we were assigned to go call the POA's (Power of Attorneys) or tell the residents what was going on. Another staff member and I had the (E) hall. I tried to put in the Residents Progress Notes who I talked to but, I don't know about my partner or any of the other ones what they did or told the residents and/or their families. I have been so upset about all this; spent all weekend crying. They did it in such a way that stripped them (Residents) of their dignity, rights and basically left them in a very fragile emotional state of mind. They were lined up like cattle going to slaughterhouses. They tossed all of their belongings out in the hallways in trash bags and many of the residents saw what was happening to all of their personal belongings. (Resident #8) was sitting at the back with other residents they had lined up awaiting transport. He waved at me and I went back to him and he was unable to talk but was shaking his head; grabbed my arm hanging onto it. I told him it was going to be okay and he would be taken care of. But I felt like I was lying to him trying to make him feel better about what was going on. (Resident #9) is a very depressed resident and has a tendency to cry anyway; she was sitting in her wheelchair with tears running down her face. I tried to console her as well. She is non-verbal most of the time. (Resident #5) was in his room and he asked me, 'Can you tell me where he's going (pointing at his roommate; (Resident #10). He said I'd like to go where he's going because I've always looked after him.' I told him I would check. I did but, they did send them to separate facilities. I was told (Resident #10) expired shortly after the move but I do not know what from. I felt like the DON, SSD could care less and just wanted to get this done. The DON did not come out of her office much at all on the 18th and 19th to help us nor console any of the residents. There was no notice given to anyone and no one was given an option to stay. n. On [DATE] at 4:26 PM, the Director of The Office of Long-Term Care (OLTC) received a call from Regional Personnel #1. She was asked how the decision was made to make (Facility

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	045259	A. BUILDING _____ B. WING _____	**04/06/2020**

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F 0835 **Level of harm -** Actual harm **Residents Affected -** Some	(continued... from page 11) #1) a facility that would take COVID residents. Regional Personnel#1 stated the Corporate Managers met several weeks ago (approximately first week of March) and made the decision that they needed a facility in each of the 8 states in which they own homes to be a receiving facility for COVID positive and presumptive and any Upper Respiratory Infections. They picked (Facility #1) because it was centrally located and had a low census. She was asked if the other states were given the resident a choice to stay and she said yes, there was a man in one of their Illinois facilities wanted to stay and we let him. She was asked what the rush was to transfer the residents out so quickly at (Facility #1) and she replied that she was informed that every resident was notified and agreed and there were not any problems with the facility decision. She was asked if the facility received anything in writing about the type of residents they would accept and how to care for them. She stated that she would send the process/guidance that was provided to the facilities. o. On [DATE] at 2:00 PM, the Chief Operating Officer (COO) was interviewed via phone and was asked what was the hurry to get the residents out of (Facility #1). He said, First the ideal concept was trying to get a handle to COVID admissions. One of the discussions today was that we won't be able to deny admissions with COVID. This was not a directive from anyone. We as a Corporation put this in place for screening and for a place for residents to go. Trying to be pro-active during this COVID-19. We spoke with American Healthcare Association. We are just trying to follow the changes and try to get ahead of this and be pro-active. CMS (Center for Medicare/Medicaid Services) or the State Office were not notified because I was under the impression all residents were in agreement to leave. (Facility #1) has the piped in oxygen and would be the best place to admit the residents whom hospitals won't be able to house. p. On [DATE] at 10:16 AM, the Maintenance Director was interviewed by phone and he was asked what his involvement was when all of the residents were discharged on [DATE] and [DATE]. He said, I was at the facility on the 18th and 19th when our previous residents were all discharged to various facilities. I don't know when or what the residents and families were told the reason for discharge was. I did see staff putting residents' personal belongings in bags, but I think they left them in their rooms not in the hallways. I did hear staff say they were going to trash residents' belongings. I was not up there during the move, so I don't know anything during discharges. The camera goes back 72 hrs. I checked that this morning. I think somebody has been in there messing with it. But we've had storms before in the past and it will shut camera system down. I have not been told to lie to you. The camera system is an old system and I feel like it was the storms last night and this morning were to blame for it appearing that someone had been messing with the system as it has in the past. q. On [DATE] at 2:35 PM, the Director of OLTC was called by (Employee #1) and she informed her that there were three residents that truly did not want to leave the facility and one in particular refused to go, his name is (Resident #13) now at (Facility #2) and went back to his room and was one of the last to go, not sure who talked him into going. (Resident #12) also now at (Facility #2) was another resident that refused to go, and she said, this is my home. (Resident #12) had a private room and it was fixed up very nice. Another resident that was told they would be transferring went to her room and cried and shook her head, she did not want to go and I told her that we are being told that this has to be done but I will make sure you are one of the last ones to leave. She stated that at the time of the resident transfers the facility had 5 residents on 'bed hold' because they were at the hospital. This surveyor asked her if these residents we
F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Many	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Complaint # (AR 412) was substantiated, all or in part, with these findings. Complaint # (AR 410) was substantiated, all or in part, with these findings. Complaint # (AR 452) was substantiated, all or in part, with these findings. Based on observation, record review and interview the facility failed to ensure through competency check offs and return demonstration that all personnel were adequately trained in the use of Personal Protective Equipment (PPE) for all types of isolation; including the use of PPE for COVID-19 and were adequately trained on standard and transmission-based precautions to be followed to prevent the spread of infections. Failed to ensure personnel were not wearing PPE out of residents' isolation rooms and in and out of the building. Failed to ensure employees were consistently screened for COVID-19 upon entering the building and; Failed to ensure the facility had a current Infection Control Policy and Procedure other than the COVID-19 policy and procedure for 6 (Residents #20 - #25) of 8 sample elected residents (total census: 64) per a list provided by the Director of Nursing (DON) via e-mail on 4/3/20 at 1:21 PM. The findings are: I. SAMPLE SELECTED RESIDENTS: a. Resident #20 was admitted to the facility on [DATE] with a [DIAGNOSES REDACTED]. b. Resident #21 was admitted to the facility on [DATE] with a [DIAGNOSES REDACTED]. c. Resident #22 was admitted to the facility on [DATE] with a [DIAGNOSES REDACTED]. d. Resident #23 was admitted to the facility on [DATE] with a [DIAGNOSES REDACTED]. e. Resident #24 was admitted to the facility on [DATE] with a [DIAGNOSES REDACTED]. f. Resident #25 was admitted to the facility on [DATE] with a [DIAGNOSES REDACTED]. II. OBSERVATION(s): a. On 3/25/2020 at 5:46 PM, Resident #20 was residing on B Hall and had a PPE bin outside her door that had mask, gowns, gloves and shoe booties. There were no N95 masks. b. On 3/30/2020 at 4:30 PM, observed the Social Service Director in front hall, outside of Administrator's Office wearing PPE shoe covers and had come from the hall where residents on various types of isolation resided. c. On 3/30/2020 at 5:15 PM, observed a male Certified Nursing Assistant (CNA) coming from hallway to the right of the Nurses Station where resident's resided with various types of isolation. He was wearing PPE hat and proceeded to walk in front of Nurses Station with Social Service Director (now not wearing PPE shoe covers) toward the front of the facility. III. STAFF INTERVIEWS: a. On 3/20/2020 at 5:16 PM, the Director of the Office of Long-Term Care (OLTC) conducted a phone interview with the Regional Director of (Corporation). She asked what was going on at the (Facility in Little Rock). The State Office had received a general complaint from a family member and the caller informed our office that this facility had transferred all the residents out because of COVID. The Regional Director replied that 53 of 54 were transferred out and the DMS (Division of Medical Service) 702's (Notice of Admission, Discharge, or Transfer from a facility) were completed yesterday. There isn't any COVID. She stated the residents were sent to the sister facilities within 3 days except for 4 families that requested other placements. She stated that they are doing deep cleaning on the facility, will have 1 hall for positive COVID and another hall for presumptive COVID. The Director OLTC made the statement that it would have been a good idea for them to notify the OLTC in advance as to their plan. The Regional Director said that the Corporation wanted to get out in front of this COVID and that they had implemented this in the other stated where they own Nursing Homes. b. On 3/25/2020 at 5:46 PM, entered the facility. The DON was on staff and there was a new admit just a few minutes prior to surveyors arriving. Shortly after entering the facility the DON received a call from the Administrator and after they spoke for a few minutes the Administrator asked to speak to the surveyor. She wanted to know if she needed to come to the facility and she was informed that wasn't necessary and her interview could be conducted over the phone. The Administrator was asked if the Medical Director was involved with the Corporate decision to transfer all the residents and she said, he wasn't informed until it was already happening, and he was upset. The DON was asked if she had anything in writing as to what type of admits she could take and how to care for them, she said that she was told that (Facility #1) would admit residents with Upper Respiratory Infections and they would be on the right side of the building and then after 14 days they could go back to the (Corporation) facility that they came from but if they want to stay they would be moved to the left side of the building. She was asked if the care for these residents would be any different such as increased monitoring for temperature and O2 (oxygen) saturations and she stated, Yes. The DON looked on her cell phone for an email with instructions from Corporate and said she was sure she had something but was unable to find it right away. She stated that she would email it to the surveyors when she found it. c. On 3/25/2020 at 5:52 PM, after completing the surveyors employee screening form and taking the surveyors temperature the DON stated that staff and residents will be admitted through the right side of the building (B Hall). That's where they will start placing residents. Residents that are compromised and/or have respiratory issues will be on the right side of the facility. The left side will house the residents that are less compromised. Only visitors will come through the front door, where they will be screened. Staff and residents will be screened either on the right or left side of the building. Per Certified Nursing Assistant (CNA #1) and the DON there were no PPE in Central Supply. All PPE, except what is in a bin placed outside of the resident's room, is now located in the Admission Office. Per the DON she doesn't have access to that room. Per the Administrator, only she has a key to that room to keep theft down. The Administrator stated that she does not have any N95 masks in the building. The DON stated that Corporate has them on order. Per CNA #1 they have 42-45 full bottles of hand sanitizer. Unable to verify this because it's all locked up in the office. They did have 2 bottles at the front desk. Per the DON she had not received any guidance related to how to care for the residents during their brief 14-day visit. Residents are to be admitted from the hospital from sister facilities, then stay for 14 days, then be sent back to their original facility. She stated they will be admitting 2 residents tomorrow and she knows 1 has Pneumonia. She was asked if she received any guidelines and/or guidance from Corporate or the Administrator on how to properly care for

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F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	(continued... from page 12) the admitted residents. She stated she would look through her email. She was asked what the urgency was to get the residents out and she stated, Corporate came and met with us. We are now accepting overflow. We'll take residents from (Facility #2, #3, #4 and #5). All have to come here if they've been sent to the hospital. She stated if the resident is positive for COVID-19 they cannot be admitted to the facility. At the time of the visit the DON was unable to locate any guidance from the facility. The DON was asked to email what guidance she had received on how to care for the residents being admitted . d. On 3/25/2020 at 7:39 PM, an email was received from the DON and it stated, . spoke with (Nurse Consultant) and (Regional Director) and they will be getting me documentation on how the decisions with admission process was made. e. On 3/26/2020 at 3:19 PM, the Director of the Office of Long Term Care (OLTC) received a phone call from the Regional Director for (Corporation) who informed that (Regional Personnel #1) would be calling and would explain the plans and that she would also provide something in writing regarding how the facility would operate now (post transfer of all the residents). The Regional Director informed that (Regional Personnel #1) was still tweaking this process . f. On 3/26/2020 at 4:26 PM, the Director of OLTC received a call from (Regional Personnel #1). She was asked how the decision was made to make (Facility #1) a facility that would take COVID residents.She stated the Corporate Managers met several weeks ago and made the decision that they needed a facility in each of the 8 states in which they own homes to be a receiving facility for COVID positive and presumptive and any Upper Respiratory Infections. They picked (Facility #1) because it was centrally located and had a low census. She was asked if the other states gave the resident a choice to stay and she said yes, there was a man in one of their Illinois facilities wanted to stay and we let him. She was asked what the rush was to transfer the residents out so quickly at (Facility #1) and she replied that she was informed that every resident was notified and agreed and there were not any problems with the facility decision. She was asked if the facility received anything in writing about the type of residents they would accept and how to care for them. She stated that she would send the process/guidance that was provided to the facilities. g. On 3/26/2020 at 4:30 PM, Licensed Practical Nurse (LPN) #2, after a previous interview called back to surveyor and stated, At first we did not have any mask and were given tri-fold paper towels with rubber bands to use as mask. There were no N95 mask in the building but have been told (Nurse Consultant) is supposed to be bringing. h. On 3/29/2020 at 2:35 PM, the Director of OLTC received from Employee #1 who stated she had received a phone call from a CNA who was worried about Infection Control at (Facility #1) and stated the CNA informed her there were 5 residents in the facility and staff are walking in and out to the building, using PPE inside and outside the building and no re-screening of staff as they are coming in and out. i. On 3/30/2020 at 4:07 PM, upon entrance to the facility Employee #3 took both surveyors temperatures and had them to fill out a screening form. She was asked how they are doing their screening process. She stated, Anybody that comes into the facility is screened. If the staff just run to their cars when they come back in, they are screened again. I was not getting everyone at first, but I am getting better at catching them now. j. On 3/30/2020 at 4:32 PM, the Administrator was asked where their PPE was being stored and she showed the surveyors the storage that was in an office across from the Administrators office. She stated, We don't have any N95 masks here, they are being stored at (Facility #3). In this storage area were multiple cases of gowns, gloves, surgical masks, fluid resistant mask with shields and shoe covers. There were no N95 masks. k. On 3/30/2020 at 4:35 PM, Employee #3 was asked if she had ever witnessed staff going outside the building with PPE on. She stated, Today (CNA #1) had his hat on (PPE) and went outside and came back in with it on. This was approximately 12 or 1 around lunch time. I've seen nurses walk from the isolation area and walk around the facility with shoe covers on without changing them. The Social Worker has been walking about the facility with shoe covers on without changing them. I seen a CNA walk from the isolation area go into the kitchen to get food for a resident with PPE on. The CNA had on a hat, shoe covers and gloves. This was for the first resident admitted after all the others were transferred out. l. On 3/30/2020 at 5:09 PM, an interview was conducted with LPN #1. She was asked if she had received an in-service from the facility regarding Infection Protocol. She stated, Last week the DON sent around an in-service on different types of isolation protocols like contact and droplet but nothing specific on COVID-19. m. On 3/31/2020 at 4:16 PM, an interview was conducted with the DON and she was asked if staff had been in-serviced regarding the use of PPE. She stated, I had a printout that I gave them. I went out to the Nurses Station and told them about the in-service and this is what they would be doing. She was asked if she had done return demonstrations with the staff. She stated, No I did not do return demonstration because they told me they understood. It's a learning curve, I'm new. They have been working in Long Term Care a long time they know how to do it. The DON was then asked for the in-service she had provided for her staff. n. On 4/1/2020 at 4:36 PM, an interview was conducted with the DON and she was asked if she was aware of the facility's COVID-19 Response Plan and that it contained competency check off with return demonstration for validation that staff had a good understanding of donning and doffing (putting on and removal) of PPE. She stated, No, I did not. After you talked with me yesterday, I started training the staff with a video and doing return demonstration. I did not know about the return demonstration of PPE check off list. I did start this yesterday after you talked to me. o. On 4/3/2020 at 8:54 AM, an interview was conducted with the Administrator and she was asked for the facility's Infection Control Policy. She stated, (Nurse Consultant) told me the COVID-19 instructions from the CDC (Centers for Disease Control) is what we are using for our Infection Control Policy. p. On 4/3/2020 at 10:03 AM, an interview was conducted with the Nurse Consultant and she was asked if there was a reason there were no N95 masks at the designated COVID facility, (Facility #1). She stated, I had no knowledge there were no N95 masks at (Facility #1). There are no positive cases there at this time. She was asked since the facility had been designated for at-risks residents should there be N95 masks available and she stated, Yes, I will check on this. She was then asked who was responsible for making sure the PPE competency with return demonstration for donning and doffing was completed on all the staff. She stated, The DON. I told the DON prior to bringing in any residents that all staff had to do competency check offs with return demonstration of the PPE. She was asked who checked off the DON and she stated, I do not know. We had an Infection Preventionist at the time, but she is no longer there. q. On 4/3/2020 at 10:43 AM, an interview was conducted with the DON. She was asked if she had been instructed by the Nurse Consultant to do return demonstrations of donning and doffing of PPE prior to receiving at-risk residents. She stated, (Nurse Consultant) never told me to do any competency check offs with return demonstration. I did the in-service because I knew it needed to be done. She was asked if anyone checked her off and she stated, No, I wasn't checked off. r. On 4/3/2020 at 3:41 PM, an interview was conducted with the Administrator after receiving a copy of the facility's Infection Control Policy. She was asked about our earlier conversation and she had stated she was told that the COVID-19 was what was being used now. She stated, I found this when looking for the Infection Preventionist job description. She was asked if this policy was being used and she stated, I'm sure with things like handling of laundry, yes they are using it but most everything is being concentrated on the COVID-19. She was asked if there was training of staff with return demonstration of donning and doffing of PPE and she stated, I talked to the DON and she started that immediately after you talked to her the other day. She was asked if it had been done prior to accepting residents and she stated, No. s. On 4/9/2020 at 8:54 AM, a phone call was placed to the DON and she was asked how many of each they have in the facility: IV (intravenous) solutions of D5W ([MEDICATION NAME] 5% in water) and Normal Saline and IV start kits. She stated, I will have to go check and call you back. t. On 4/9/2020 at 9:30 AM, spoke with the DON via phone and she stated, We have 10 IV start kits, 1 (1 liter bag) Normal Saline 0.45%, 1 (1 liter bag) Normal Saline 0.9% and 1 (1 liter bag) of [MEDICATION NAME] with Normal Saline 5%. IV: INSERVICE AND POLICY AND PROCEDURE(S): a. On 3/27/2020 at 1:27 PM, a policy was received via email from (Corporate Personnel #1) that documented, Rapid Response Plan COVID-19 March 13, 2020 Purpose: Out of abundance of caution and in an effort to contain or mitigate the spread of COVID-19, Designated Facilities will be appointed in each state. This move is being made to protect our vulnerable population and to allow adequate supplies, heightened awareness, advanced training skills and rapid response to the rapid spread of COVID-19. Plan: . Designated Facilities will receive par levels of PPE including N95 masks, isolation gowns, eye protection, head shields, gloves. Other supplies will immediately be sent to the Designated Facilities including but not limited to: alcohol based hand sanitizer, no-touch thermometers, pulse oximetry devices, 50 bags of D5W, 50 bags of Normal Saline, 100 IV starter kits, . Educate all staff on Infection Control Guidelines, Proper Donning and Doffing with competencies, Proper Hand Washing with competencies. . b. An in-service provided by the DON via email on 4/1/2020 at 3:25 PM documented, Inservice Topic: PPE Use Date of Inservice: 3/24/2020 Inservice by: (DON) Please follow instruction for sequence for Donning and Removing Personal Protective Equipment (PPE). Please See Attachment. Sign indicating you acknowledged the information provided. This form had 18 signatures. Attached to this was 2 pages of instructions with pictures. c. On 4/2/2020 at 4:29 PM, a policy was provided by the Administrator via email. This policy documented, COVID-19 Vigilant-And Prepared March 2020 . COVID-19 Response Plan . Clinical Documents Personal Protective Equipment Competency. Personal Protective Equipment (PPE) Competency Validation Donning and Doffing Standard Precautions on Transmission Based Precautions. Type of Validation: Return Demonstration . This

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F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Many	(continued... from page 13) form had areas to be checked for observed competency of both donning and doffing PPE. Per interviews with the DON and Administrator this was not done until the DON was interviewed by the surveyor and was asked what training had been provided to the staff.