STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045377	A. BUILDING _____ B. WING _____	**09/17/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
THE GREEN HOUSE COTTAGES OF SOUTHERN HILLS	**701 SOUTH MAIN STREET RISON, AR 71665**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0550 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - 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** Based on observation and interview, the facility failed to ensure staff sat at eye level to promote dignity and respect for 1 resident (Resident #2) of 4 (Residents #1, #2, #3 and #4) case mix residents who were dependent on staff for feeding. This failed practice had the potential to affect 4 residents in Cottage #6 that were dependent for feeding according to a list provided by the Administrator on 09/15/2020. The findings are: Resident #2 had a [DIAGNOSES REDACTED]. The Quarterly Minimum Data Set with an Assessment Reference Date of 08/17/2020 documented the resident scored 09 (08-12 indicates moderately impaired) on the Brief Interview for Mental Status and required limited assistance of one person for eating. a. On 09/14/2020 at 12:00 p.m., Resident #2 was sitting in her wheelchair at the dining room table. Certified Nursing Assistant (CNA) #4 was standing while feeding Resident #2. CNA #4 was asked, Should you stand while feeding a resident? CNA #4 stated, I don't like to sit down while feeding the resident. b. On 09/14/2020 at 12:09 p.m., CNA #4 continued to stand while feeding Resident #2. CNA #4 was asked, Should you stand while feeding a resident? CNA #4 stated, I don't like sitting to feed residents. c. On 09/14/2020 at 12:25 p.m. CNA #4 continued standing while feeding the resident. She was asked, Should you maintain resident's dignity by not standing while feeding the resident? She did not respond. Licensed Practical Nurse #2 stated, .No, she should not be standing while feeding a resident.
F 0584 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the facility failed to ensure a resident's room remained free of a urine odor and the bed linen remained free of stains for 1 of 1 (Resident #4) who resided in Cottage #2. This failed practice had the potential to affect 12 residents who resided in Cottage #2 according to the Daily Census report provided by the Administrator on 09/14/2020 at 10:15 a.m. The findings are: Resident #4 had a [DIAGNOSES REDACTED]. a. On 09/15/2020 at 12:10 p.m., Resident #4's room had a strong smell of urine permeating out into the hallway and the bed was un-made. There was a large clear stain surrounded by a large brown tannish ring on the sheets. Licensed Practical Nurse (LPN) #1 was exiting another resident's room and was asked to accompany this surveyor to Resident #4's room. As we entered the hallway of the room LPN #1 was asked, What is that odor? LPN #1 did not reply and continued down the hallway and entered Resident #4's room. She was asked, What is that odor and what are the stains on the resident's bed. LPN#1 stated, It smells like urine. The resident could have had an accident in the bed. She will go to the bathroom herself. LPN #1 donned gloves, touched the stains on the resident bed and stated, It's wet. LPN #1 was asked, Should resident's room and the hallways remain free of strong urine odors? She stated, Yes, Ma'am. She was asked, Should the resident's bed remain free of clear and brown urine stains? She stated, Yes, Ma'am. She was asked, Where is the resident? LPN #1 stated, She's in the dining room eating.
F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Provide and implement an infection prevention and control program.** Based on observation and interview the facility failed to ensure implementation of proper infection prevention and control practices to prevent the development and transmission of COVID-19 and other communicable diseases and infections by not properly wearing face masks to cover the mouth and nose. This failed practice had the potential to affect 12 residents who resided in Cottage #6 and 12 residents who resided in Cottage #2 as documented on the Daily Census Report provided by the Administrator on 09/15/2020 at 10:15 a.m. The findings are: 1. On 09/14/2020 at 12:20 p.m., Nursing Assistant (CNA) #3 was standing at the dining room counter in Cottage #6 talking on the facility phone. CNA #3's face mask was underneath her chin the entire length of the phone conversation. There were un-masked residents sitting in the dining room eating their meal. 2. On 09/14/2020 at 12:34 p.m., CNA #3 ended her call and without her facemask covering her mouth and nose walked around in the kitchen. CNA #3 was asked, Should your mask cover your mouth and nose while in the facility? She stated, But they couldn't hear me while I was on the phone. 3. On 09/14/2020 at 12:39 p.m., in Cottage #2, CNA #1 was sitting at the dining room table eating and feeding Resident #3. CNA #1's face mask was beneath her chin and the female resident did not have a facemask on. CNA #1 did not sanitize her hands between eating and feeding the resident. CNA #1 was asked, Should you sanitize your hands between eating and feeding a resident? She stated, Yes. She was asked, Should you wear a face mask while feeding a resident? She stated, Yes, ma'am She was asked, Should you eat while feeding a resident? She stated, They want us to eat with the residents. She was asked, Who wants you to eat with the residents? She stated, That's what I was told when started working here. 4. On 09/14/2020 at 12:39 p.m., CNA # 2 was sitting at a dining room table eating, her facemask was underneath her chin. Without placing her facemask over her mouth and nose, she left the dining room table, walked down the hallway and entered a resident's room. She then, exited the room, without her face mask covering her mouth and nose, and walked down the hallway back to the dining room table, and continued eating. 5. On 09/14/2020 at 12:48 p.m. CNA #2 was asked, Should you wear your facemask while in the facility? She stated, Yes.

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.