STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045148	A. BUILDING _____ B. WING _____	07/02/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CAVE CITY NURSING HOME INC	442 TAYLOR CIRCLE CAVE CITY, AR 72521

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0550 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, and interview the facility failed to ensure dignity was maintained by not referring to a resident as a feeder for 1 of 1 (Resident #36) who required assistance with meals. This failed practice had the potential to effect 13 residents in the facility who required assistance with meals according to a list provided by the Director of Nursing (DON) on 7/2/2020 at 4:05 p.m. The findings are: Resident #36 had [DIAGNOSES REDACTED]. The Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 4/25/2020 documented the resident had modified independence in cognitive skills for daily decision making on a Staff Assessment for Mental Status (SAMS) On 06/29/2020 at 12:51 p.m., Licensed Practical Nurse (LPN) #2 was asked if the resident was able to feed herself, or is she required assistance? LPN #2 stated, She's a feeder. LPN #2 was asked, Does she require assistance at every meal? LPN #2 stated, Yes. She's a feeder, we feed her every meal.
F 0583 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Keep residents' personal and medical records private and confidential.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview the facility failed to ensure privacy was provided during a dressing change for 1 (Resident #36) of 5 sample residents who had dressing changes. This failed practice had the potential to effect 18 residents who had dressing changes according to a list provided by the Director of Nursing (DON) on 7/2/2020 at 8:48 AM. The findings are: Resident #36 had [DIAGNOSES REDACTED]. The Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 4/25/2020 documented the resident had modified impairment in cognitive skills for daily decision making on a Staff Assessment for Mental Status (SAMS) a. The Care Plan with a review date of 4/25/2020 documented . Resident #36 has risk of pressure ulcer review of physical condition, requires total to extensive care and services 3/19/20 IDT (Interdisplinary Team) discussed new area to Left Shin with risk of further areas discussed with current condition and abilities, and left heel DTI (deep tissue injury). Date Initiated: 12/14/2018 Revision on: 04/14/2020 . b. Physician order [REDACTED].cleanse left heel with wound cleanser, pat dry, apply [MEDICATION NAME] and cover with dry dressing. every day . c. On 06/30/2020 at 09:39 and at 10:08 a.m., Licensed Practical Nurse (LPN) #1 pushed the drape between the two beds back in preparation for the pressure ulcer treatment on residents left heel. The resident in the bed next to the resident could easily see what care was being provided for her roommate. Resident #36 roommate watched the care provided during the pressure ulcer dressing change.
F 0641 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Ensure each resident receives an accurate assessment.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure Minimum Data Set (MDS) assessments accurately reflected a resident's current status to provide accurate information with which to develop a Care Plan to meet the resident's needs for 1 resident (# 54) who was receiving [MEDICATION NAME]. This failed practice had the potential to affect 6 residents who are currently receiving [MEDICATION NAME] as documented on a list provided by the Director of Nursing (DON) on 7/2/2020. 1. Resident #54 had a [DIAGNOSES REDACTED]. staff member for personal hygiene; and required limited assistance x1 staff member for eating. a. The July 2020 physician orders [REDACTED]. b. The updated Care Plan documented, .Give all medications as ordered by the physician. observe and document side effects. Report Adverse reactions to MD (doctor) PRN (as needed). review all orders - meds (medications) quarterly and md - transport to any appts as directed / [MEDICATION NAME] per md order for [MEDICAL CONDITION] . c. The MDS with an ARD of 5/23/2020, noted Medications Received, Medications received: Days: Anticoagulants, documented the resident had received an anticoagulant in the 7 days d. The June 2020 Medication Administration Record [REDACTED]. e. On 7/2/2020 at 2:37 p.m., the Director of nursing (DON) was asked, Are you familiar with (Resident #54)? and she stated, Yes. She was asked, Is she on an anticoagulant? and she stated, Let me look. She is on [MEDICATION NAME]. She was asked, Is [MEDICATION NAME] an anticoagulant? and she stated, For us its listed as hematological agent. She was asked, On her most recent MDS, it was coded that she had been taken an anticoagulant for the past 7 days. Was [MEDICATION NAME] coded as an anticoagulant? The DON called another staff member and asked about the MDS coding of anticoagulant. The DON stated, She told me that it is antiplatelet, so it was miscoded.
F 0657 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to ensure the residents Plan of Care was revised to reflect the current needs of 3 (Residents #59, #38, and #54) of all 66 residents with care plans. This failed practice had the potential to affect all 66 residents who resided in the facility, as documented on the Resident Census and Conditions of Residents report provided by the Assistant Administrator on 6/29/2020. The findings are: 1. Resident #38 had a [DIAGNOSES REDACTED]. The Annual Minimum Data Set (MDS) with an Assessment Reference Data (ARD) of 4/25/2020 documented the resident scored 3 (3 indicates severely impaired) on a Staff Assessment Mental Status (SAMS); required extensive assistance x (times) 2 staff members with bed mobility, transfers, dressing, toilet us, and personal hygiene; and required limited assistance x1 staff member for eating. a. A record review of the updated care plan was completed, and no interventions were implemented/documented for nail care. 2. Resident #54 was admitted on [DATE] with the [DIAGNOSES REDACTED].; and limited assistance x1 staff member for eating. a. A record review of the updated care plan was completed, and no interventions were implemented for the use of bed rails. 3. Resident #59 was had a [DIAGNOSES REDACTED]. The Quarterly Minimum Data Set (MDS) with an Assessment Reference Date of 6/3/2020 documented the resident scored 15 (13 - 15 indicates cognitively intact) on a Brief Interview Mental Status (BIMS); and required limited assistance x1 staff member with transfers, dressing, toilet use; set up with bed mobility; and was independent on personal hygiene. a. A record review of the updated care plan was completed and no interventions were implemented for the positioning devices for contractures and the use of bed rails. b. On 7/2/2020 at 2:40 p.m., the Director of Nurses (DON) was interviewed and asked, What all should be care planned in a resident's chart? and she stated, Everything that goes into their care. She was asked, When should the care plan be revised or updated? and she stated, Whenever there is a change, and something is added. She was asked, Should the use of bed rails, nail care, and contractures/position devices been care planned? and she stated, Yes.
F 0677 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide care and assistance to perform activities of daily living for any resident who is unable.**

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 0677 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 1) **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview the facility failed to ensure residents fingernails were trimmed, free from jagged edges, and clean to promote good personal hygiene for 2 (Residents #38 and #54) of 4 sampled residents who were dependent on staff for nail care. This failed practice had the potential to affect 9 residents who were dependent on staff for nail care on the 200 hall as documented by a list provided by the Director of Nursing (DON) on 7/2/2020. The findings are: 1. Resident #54 had a [DIAGNOSES REDACTED]. dressing; required extensive assistance x1 staff member for personal hygiene and limited assistance x1 staff member for eating. a. The most recent Care Plan dated documented, .Provide Nail Care Q (every) 90 Days and PRN (as needed) . b. On 6/29/2020 at 1:39 PM, Resident #54's fingernails were dirty and had a brown substance underneath the nails. c. On 6/30/2020 at 10:15 AM, Resident 54's fingernails to be dirty and had a brown substance underneath the nails. 2. Resident #38 had a [DIAGNOSES REDACTED]. The Annual Minimum Data Set (MDS) with an Assessment Reference Data (ARD) of 4/25/2020 documented the resident was severely impaired in cognitive skills for daily decision making on a Staff Assessment Mental Status (SAMS); and required extensive assistance x 2 staff members with bed mobility, transfers, dressing, toilet us, and personal hygiene; and requires limited assistance x1 staff member for eating. a. The updated Care Plan documented, .Husband will have personal beauty operator to come and cut hair and nails . b. On 6/29/2020 at 2:57 PM, the resident's nails were dirty and had a brown substance underneath the nails. c. On 6/30/2020 10:45 AM, the resident's nails were dirty and had a brown substance underneath the nails. d. On 7/2/2020 at 2:08 pm Nursing Assistant (NA) #1 was asked, Who is responsible for nail care? and she stated, CNAs (Certified Nursing Assistants) unless the resident is a diabetic. She was asked, When is nail care done? and she stated, As needed. She was asked, What if a resident refuses?' and she stated, Try again later and report to the nurse. She was asked, What do you do when you notice a resident's nails are dirty? and she stated, Ask if I can clean them or assist them with cleaning. e. On 7/2/2020 at 2:14 PM Licensed Practice Nurse #3 (LPN) was asked, Who is responsible for nail care? and she stated, The non-diabetics is the CNA's and the diabetics is me. She was asked, When is nail care done? and she stated, As needed or upon request. She was asked, What if a resident refuses? and she stated, They are allow to refuse then notify the Director of Nursing. She was asked, What do you do when you notice a resident's nails are dirty? and she stated, Clean them. f. On 7/1/2020 the Director of Nursing provided a document titled Providing Nail Care documented, .The purpose of this procedure is to provide guidelines for the provisions of care to a resident's nails for good grooming and health . and Routine nail care, to include trimming and filing, will be provided on a regular schedule. Nail care will be provided between scheduled occasion as the need arises .
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 observation, record review, and interview the facility failed to ensure antifungal powder was administered only when ordered by a physician and administered by a licensed nurse for 1 (Resident #42) sample mix resident. This failed practice had the potential to affect 4 residents who had a physician's orders [REDACTED]. The findings are: Resident #42 had [DIAGNOSES REDACTED]. The Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 5/3/2020 documented the resident scored 12 (8-12 indicates moderately impaired) on a Brief Interview for Mental Status (BIMS); required extensive two-plus person assistance with transfers and toilet use and was always incontinent of bladder and occasional incontinent bowel. a. On 6/29/2020 at 3:07 PM, CNA #1 was observed during peri - care, applying anti-fungal powder to the resident's pubic area. b. The front of the Antifungal Powder bottle documented, .Phytoplex [MEDICATION NAME] Nutrition for Sensitive Skin .Antifungal Powder .[MEDICATION NAME] 2% (percent) . c. On 6/29/2020 at 3:11 PM, CNA #1 was asked, Is the antifungal powder a medication? She stated, I don't know. The CNA was asked, Who told you, you could apply the antifungal powder? She stated, The CNAs who orientated me applied it. d. On 6/29/20 03:15 PM, the DON, was asked, Are CNAs allowed to apply antifungal powder? She stated, Yes. Not prescription antifungal powder, but over the counter they can. The DON was asked, Is antifungal powder a topical medication? She stated, Yes. The DON was asked, Does the resident have an order for [REDACTED]. The DON was asked, How did the resident get the antifungal powder that was in her drawer? She stated, It was left in the resident's room. i. The Policy on Medication Administration was received on 7/1/2020 by the DON and documented, .Medications are administered by licensed nurses .as ordered by the physician and in accordance with professional standards of practice .
F 0688 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview the facility failed to ensure a positioning device was consistently utilized to decrease the potential for further decline in range of motion for 1 (Residents #59) of the 3 (Resident #21, 54, and 59) sample residents who had contractures. This failed practice had the potential to affect 3 residents who had contractures as documented by a list provided by the Director of Nursing (DON) on 7/2/2020. The findings are: Resident #59 had a [DIAGNOSES REDACTED]. The Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 6/3/2020 documented the resident scored 15 (13 - 15 indicates cognitively impaired) on a Brief Interview Mental Status (BIMS); required limited assistance x (times) 1 staff member with transfers, dressing, toilet use; set up with bed mobility and independent on personal hygiene. a. The July 2020 physician orders [REDACTED]. b. The updated Care Plan was reviewed, and no documentation was found related to positioning devices. c. On 6/29/2020 at 2:43 PM, the resident's left hand was contracted with no positioning device. d. On 6/30/2020 at 11:02 AM, the resident's left hand was contracted and had no positioning device in place. The positioning device was hanging on the trapeze bar; the resident stated therapy as supposed to be putting on the brace, but they were over worked and had no time. The resident could not open his left hand. The resident was asked, Can you open you left hand? He stated, No. I have to move it with my other arm. e. On 7/2/2020 at 2:00 PM the Certified Nurse's Assistant (CNA) #2 was asked, Who takes cares of the positioning devices for residents who have contractures? She stated, CNAs and nurses. She was asked, What do you do if a resident refuses the device? She stated, Try again in a few minutes. She was asked, Should it be care planned? She stated, Yes. She was asked, Should a resident with a contracture hand have a device in their hand? She stated, Yes. f. On 7/2/2020 at 2:07 PM, Registered Nurse #1 (RN) was asked, Who takes cares of the positioning devices for residents who have contractures? She stated, Treatment Nurse, nurses and the CNAs. She was asked, What do you do if a resident refuses the device? She stated, Educate the resident and try again and then tell the DON. She was asked, Should it be care planned? She stated, Yes. She was asked, Should a resident with a contracture hand have a device in their hand? She stated, Yes. g. On 7/2/2020 the Director of Nursing provided a document titled Range of Motion that documented, .residents with limited range of motion will receive appropriate treatment and services to increase range of motion or to prevent further decrease in range of motion .
F 0689 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview the facility failed to ensure a fall intervention was implemented after a fall occurred for 1 (Resident #38) of 4 (Residents #2, #12, #19, and #34) sampled mix residents who had falls in the last 30 days. The failed practices had the potential to affect 22 residents who were at risk for falls, according to a list provided by the Director of Nursing (DON) on 7/2/2020. The findings are: Resident #38 had a [DIAGNOSES REDACTED]. The Annual Minimum Data Set (MDS) with an Assessment Reference Data (ARD) of 4/25/2020 documented the resident scored 3 (3 indicates severely impaired) on a Staff Assessment Mental Status (SAMS); and required extensive assistance x2 staff members with bed mobility, transfers, dressing, toilet us, and personal hygiene; and required limited assistance x1 staff member for eating. a. The Morse Fall Scale assessment date 2/18/2020 documented the resident is at a high risk for falling. b. The updated Care Plan documented, .Transfer:/ Risk of Falls .is at risk of falls she often will attempt to transfer self, with

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F 0689 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 2) reminders to call for assist cognitive abilities limits remembering to call for assist .4/10/20 Review resident found on floor sitting on her bottom leaned up against the ac (air conditioning) unit stated I was trying to transfer from w/c (wheelchair) to recliner no bruising or bump to head, redness to r. (right) lower back MD (doctor) and Family informed . c. The physician orders [REDACTED]. d. The progress notes were reviewed, and no documentation was found related to the intervention for the fall on 4/10/2020. e. The Incident and Accident Report was reviewed, and no documentation was found related to the intervention for the fall on 4/10/2020. f. On 7/1/2020 at 2:00 p.m., the Director of Nursing (DON) was asked, For the fall on 4/10/2020, was there an intervention put in place? and she stated, No intervention was put in place but in their defense, she already had a fall mat. g. On 7/2/2020 the DON provided a documented titled Fall Prevention Program documented, .Provide interventions that address unique risk factors measured by the risk assessment tool: medications, psychological, cognitive status, or recent change in functional status . and .provide additional interventions as directed by the resident's assessment .
F 0690 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview the facility failed to ensure proper and thorough incontinent care was provided and staff wiped from front to back when incontinent care was provided, to promote good hygiene, maintain skin integrity and prevent potential urinary tract infections for 1 (Resident #42) of 4 (Residents #39, #21, #46 and #42) case mix residents who were incontinent. This failed practice had the potential to affect 6 residents who resided on the 400 Hall and were incontinent, according to a list provided by the Director of Nursing (DON) on 7/1/2020. The findings are: 1. Resident #42 had [DIAGNOSES REDACTED]. The Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 5/3/2020 documented the resident scored 12 (8-12 indicates moderately impaired) on a Brief Interview for Mental Status (BIMS); and required extensive two-plus person assistance with transfers and toilet use and was always incontinent of bladder and occasional incontinent bowel. a. On 6/29/2020 at 3:07 PM, Certified Nursing Assistant (CNA) #1 was observed during peri - care. CNA #1 un-taped the resident's wet brief, tucked a brief between her legs, pumped foam on a wipe, and wiped down right groin. CNA #1 retrieved a new wipe / foam and wiped down left groin, another wipe across suprapubic, grabbed a new wipe, reached between resident's legs and wiped upwards, and back to front times one. CNA #1 asked the resident to roll on her right side. CNA #1 removed the soiled brief, tucked in a new brief and, applied barrier cream. The resident then rolled on her back and CNA #1 secured the brief. b. The updated Care Plan documented, .(Resident #42) has an ADL (Activities of Daily Living) self-care performance deficit r/t (related to) .dx (diagnoses) .TOILET USE: .Clean peri-area q (every) 2 hrs (hours) and prn .apply oint after each episode report promptly any s/s with hx. review and risk of skin breakdown . c. Record review of the skin assessment completed on 6/27/2020 documented, under notes, .coccyx red/pink . d. On 6/29/2020 at 3:11 PM, CNA #1 was asked, Were you trained on peri- care? She stated, Yes. The CNA was asked, Did you have a check off sheet? She stated, Yes. The CNA was asked, When doing peri care how were you trained to clean the resident? The CNA stated, Front and back, one wipe with cleaner and wipe. The CNA was asked, When cleansing the labia, were you trained to separate the labia and wipe, front to back? She stated, Yes. The CNA was asked, What about the resident's buttocks, inner / outer thighs? She stated, I don't recall that. f. On 6/29/2020 03:15 PM, the DON was asked, How are CNAs trained to do peri - care? She stated, They clean the peri area, one wipe per wipe, front to back, between the Labia, front and back, cleanse the hips, buttocks. The DON was asked, How often are CNA in-serviced on peri-care? She stated, At first hire, as needed, and the last time was 6/5/2020. The DON was asked, Who monitors the CNA's to ensure they are performing proper peri-care? She stated, The lead CNA, me and the ADON (assistant director of nursing). g. The Perineal Care Policy received from the DON on 7/1/2020 documented, .It is the practice of this facility to provide perineal care to all incontinent residents .as needed in order to promote cleanliness and comfort, prevent infection to the extent possible, ad to prevent and assess for skin breakdown .Females: Assist resident in bending her knees slightly and spreading her legs. .Separate the resident's labia with one hand, and cleanse perineum with the other hand by wiping in direction from front to back (from pubic area toward anus). Repeat on opposite side . Clean urethral meatus and vaginal orifice . Clean and dry the anal area, starting at the posterior vaginal opening and wiping from front to back. .Apply skin protectants as needed and according to facility policy regarding skin care. .
F 0695 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide safe and appropriate respiratory care for a resident when needed.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview the facility failed to ensure oxygen / updraft tubing and updraft mouthpiece / mask was stored in a bag or other closed container when not in use and failed to ensure bags were kept off the floor to prevent potential contamination for 3 (Resident #55, #369 and #24) of 16 (Resident #59, #24, #27, #369, #29, #62, #34, #46, #21, #44, #33, #64, #37, #26, #55, and #28) and 2 (Resident #55 and #369) of 8 (Residents #2, #24, #27, #36, #62, #64, #65, and #369) sampled residents. The failed practice had the potential to affect 37 residents who had physician's orders [REDACTED]. The findings are: 1. Resident #55 had [DIAGNOSES REDACTED]. The Modified Significant Change Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 5/19/2020 documented the resident scored 10 (8-12 indicates moderately impaired) on a Brief Interview for Mental Status (BIMS), did have shortness of breath; and received oxygen therapy. a. The update Care Plan documented, . (Resident's Name) has DX (diagnosis). OF Heart Failure .Observe For S/S (signs/symptoms) Of Complications .Oxygen Provide 02 (Oxygen) As Directed (1/30/2020 review of orders currently at 4 lpm (liters per minute)) .Change All Tubing And Humidifier Bottle As Required And Or Ordered, Re-Direct If Removes Per Self .Provide All Medications As Ordered . b. The June 2020 Physicians Orders documented, .[MEDICATION NAME] Solution 0.5-2.5 (3) MG/3ML (milligrams/milliliters) ([MEDICATION NAME]-[MEDICATION NAME]) 1 dose inhale orally three times a day related to MET[DIAGNOSES REDACTED] .O2 (oxygen) 4L (Liters) nasal cannula continuously .change oxygen tubing every 3 days every nightshift every 3 day(s) . c. On 6/29/2020 at 12:24 PM, the resident was sitting in her chair. Her oxygen was in place at 4 liters via nasal cannula, her updraft / oxygen storage bags were laying on the floor, next to garbage can, the updraft mouthpiece connected to the canister was laying on bedside table. d. On 6/29/2020 at 12:33 PM, the Licensed Practical Nurse (LPN) #1 accompanied the surveyor to resident's room and she was asked, How is the resident oxygen tubing / updraft tubing / mouthpiece stored, when not in use? She stated, In the plastic bag. The LPN was asked, Should the plastic bags be laying on the floor? She stated, No. She messes with her tubing that is why they are laying on the floor. The LPN was asked, Is laying the updraft mouthpiece on the bedside table the proper way to store it, when not in use? She stated, No. It should be stored in a plastic bag. e. On 6/29/2020 at 3:15 PM, the DON was asked, How are the oxygen tubing, the updraft tubing and or mask /mouthpiece stored, when not in use? The DON stated, In plastic bags. the DON was asked, Where are the plastic bags, placed for storage? She stated, A whole is placed in the plastic bag and the oxygen tubing is threaded through it, up to the humidifier bottle. the DON was asked, Should the plastic bags be able to slide down the tubing, and lay on the floor? She stated, No. the DON was asked, Is it sanitary for the bags to lay on the floor? She stated, No. If they do, they should be thrown away, because they are contaminated. f. On 7/1/2020, the Policy on Oxygen Safety was received by the DON document, .It is the policy of this facility to provide a safe environment for resident, staff, and the public. This policy addresses the use and storage of oxygen and oxygen equipment. .Oxygen and nebulizer tubing shall be stored in plastic bag when not in use . 2. Resident #369 had a [DIAGNOSES REDACTED]. The Admission/5-day Minimum Data Set (MDS) with an Assessment Reference Date (ARD) 6/16/2020 documented the resident scored 8 (8 - 12 indicates moderately impaired) on a Brief Interview Mental Status (BIMS); and required limited assistance x (times) 1 staff member for bed mobility, transfers, dressing, and toilet use; and set up with supervision for eating and personal hygiene; and receives oxygen therapy. a. The July 2020 physician orders [REDACTED].Change Updraft tubing every 3 days . b. The updated Care Plan documented, .OXYGEN SETTINGS: provide as directed observe for proper placement or removing per self, re-direct prn (as needed) observe for s/s (signs and symptoms) of irritation around ears or face and alert charge prn change all tubing and humidifier bottle as ordered keep therapy informed of changes and risk of sob (Shortness of Breath) . c. On 6/28/2020 at 11:48 a.m., the nebulizer administration set was lying in bed, not in a storage bag/container and the nebulizer tubing not stored in a storage bag/container. 3. Resident #24 had a [DIAGNOSES REDACTED]. a. A Care Plan with a review date of 4/13/2020 documented, .and prn (as needed) provide 02 as directed . b. The July 2020 physician's orders [REDACTED].< (less than) 92% (percent) . c. On 06/29/2020 at 01:30 PM, there was an oxygen bag resting on the floor next to the bed. d. On 06/29/2020 at 01:30 PM, CNA #3 was asked if the oxygen bags were supposed to be resting on the floor? She stated, No. They're not supposed to be on the floor .

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F 0695 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 3)
F 0760 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Ensure that residents are free from significant medication errors.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview the facility failed to ensure manufacturer's guidelines were followed to prevent a significant medication error 1 of 1 (Resident #47) sampled residents who received insulin from an insulin pen. This failed practice had the potential to affect 1 resident who received Insulin from an Insulin Pen per a list provided by the Director of Nursing (DON) on 7/2/2020. The findings are: Resident #47 had a [DIAGNOSES REDACTED]. a. The July 2020 physician's orders [REDACTED].= 0; 201 - 250 = 2; 251 - 300 = 4; 301 - 400 = 6; 401 - 1000 = 8 notify MD doctor), subcutaneously before meals and at bedtime for diabetes . b. On 07/02/2020 at 11:15 AM, during the noon medication pass, Licensed Practical Nurse (LPN) #2 removed the residents [MEDICATION NAME] Flex pen from the drawer, removed the cap, and placed a needle on the end without sanitizing the end first. LPN #2 didn't prime the pen with 2 units prior to administering to resident. c. On 07/02/2020 at 11:15 AM, during the noon medication pass, LPN #2 administered residents [MEDICATION NAME] Flex Pen into Resident 47's right abdomen, depressing the plunger, and immediately removing the pen. d. On 07/02/2020 at 11:24 AM, LPN #2 was asked to go back through her procedure for the insulin pen. The LPN asked if she wiped the end of the pen with alcohol prior to adding the needle? LPN#2 stated, No. I didn't. LPN #2 was asked, Without sanitizing the end of the Insulin Pen, is there a potential for infection? LPN #2 stated, Yes. There is a risk for infection. LPN #2 was asked, When you injected the insulin did you count to 6 to ensure the insulin was fully injected? LPN #2 stated, No. I didn't. LPN #2 was asked, What is the reason that the recommendations are to count after injecting an insulin pen? LPN #2 stated, To ensure that all of the medication is injected . e. The drug information provided documented, [MEDICATION NAME] is a disposable, single-patient us, dial-a-dose insulin pen . Prime your pen Turn the dose selector to select 2 units. Press and hold the dose button. Make sure a drop appears .Give your injection Insert the needle. Press and hold the dose button. After the dose counter reaches 0, slowly count to 6. f. The drug information provide documented: .Pull off the pen cap, wipe the rubber [MEDICATION NAME] with an alcohol swab . g. This was a significant error due to the condition of the resident and class of medication of Anti-Diabetic Insulin.
F 0805 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs.** Based on observation and interview, the facility failed to ensure pureed food items were blended to smooth, lump-free consistency to minimize the risk of choking or other complications and improve palatability for residents who required a pureed diet for 2 of 2 meal observed. This failed practice had the potential to affect 3 residents who received pureed diets, according to the Diet list provided by the Food Service supervisor on 6/30/2020. The findings are: 1. On 6/29/2020 at 3:41 p.m., Dietary Employee #2 placed 2 hamburger patties and one bun into a blender, added broth, pureed, and poured the mixture into a pan. Dietary Employee #2 covered the pan of pureed hamburger and buns with a piece of foil and placed it in the oven. The consistency of pureed hamburger and bun was not smooth. It was dry, thick and looked more of ground meat. 2. On 6/29/2020 at 4:07 p.m., Dietary Employee #2 used beef broth to prepare mashed potatoes. She did not put enough broth. She covered the pan with a piece of foil and placed it in the oven. The consistency was dry and was not formed. 3. On 6/29/2020 at 4:18 p.m.2, Dietary Employee #2 placed 5 servings of fries into a blender and pureed without liquid. At 4:22 p.m., she scooped the dry pureed fries into a pan. She covered the pan with a piece of foil and placed it in the oven. The consistency was thick and dry. 4. On 6/29/2020 at 4:52 p.m.,2 a test tray that consisted of pureed hamburger patties with cheese, pureed hamburger patties without cheese, pureed fries and mashed potatoes prepared for the residents on mechanical soft diets was obtained. Dietary Employee #2, who prepared supper meal, was asked to describe the consistency of pureed hamburger with cheese and buns, pureed hamburger without cheese, pureed fries, and mashed potatoes prepared to be served to the residents on mechanical soft diets. She stated, Pureed fries was thick and dry, pureed hamburger patties with cheese and pureed hamburger patties without cheese were dry and looked like mechanical ground meat. The Dietary Supervisor stated, Pureed fries was dried and sticky and feels like a rubber, pureed Hamburger patties with and without cheese looked more like ground meat. 5. On 6/30/2020 at 7:55 a.m., the pureed sausage served to the residents on pureed diets was not smooth. It was gritty. Nurse Assistant #1 (NA) was asked to describe the consistency of the pureed food items served to the residents on pureed diets. She stated, It was finely chopped. 6. On 6/30/2020 at 7:59 a.m., Nurses Assistant #2 was asked to describe the consistency of the pureed sausage served to the residents on pureed diets. She stated, It was chunky mashed potatoes. 7. On 6/30/2020 at 8:01 a.m., the Dietary Supervisor was asked to describe the consistency of the pureed sausage served to the residents on pureed diets. She stated, It was grease and not pureed enough.
F 0812 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Many	**Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the facility failed to ensure leftover food items were used by its use-by date to prevent potential food borne illness for residents who received meal trays; foods stored in the freezer were maintained to prevent potential for cross contamination to prevent food borne illness for residents who received meals, 2 of 2 ice machine were maintained in clean and sanitary condition to prevent contamination of airborne particles; dietary staff washed their hands between dirty and clean tasks and before handling clean equipment or food items to minimize the potential for food borne illness for residents who received meals; expired food items were promptly removed /discarded on or before the expiration or use by dates to prevent potential food borne illness for residents who received meal trays from 1 of 1 kitchen. These failed practices had the potential to affect 66 residents who received meals from the kitchen (Total Census 66), as documented on a list provided by the Food Service Supervisor on [DATE]. The findings are: 1. On [DATE] at 11:18 a.m., the following leftover foods were stored on a shelf in the refrigerator: A pan of pureed eggs, a pan of pureed sausage, and a pan of ground sausage. The Dietary Supervisor was asked what are you going to do with the food items. She stated, We warm them up the next morning at breakfast, so they can be fluffy when we serve them to the residents. I think they have mixed in scrambled eggs with the pureed eggs. 2. The Facility policy for Storage of Left-Over Foods dated [DATE] received from Dietary Supervisor on [DATE] at 10:02 a.m., documented Policy #2. B Refrigerator leftover meats will be used for pureed and ground meats and to meet the individual food preference of the resident. 3. On [DATE] at 11:36 a.m., there was an open box of dinner rolls on a freezer shelf. There was an open, clear, plastic bag with frozen biscuits inside an open box on the shelf in the freezer, exposing the biscuits to freezer burn. There were ice cycles all over the biscuits. The Dietary Supervisor stated, It has freezer burn. It has been opened and refrozen. 4. On [DATE] at 11:43 a.m., the spout to the ice machine in the dining room had lime build up and dust particles in it. The Dietary supervisor stated, We are supposed to clean it once a week, but I have not cleaned it. I usually open the top of it and clean the inside. The Dietary Supervisor was asked to wipe the residue inside the spout. She did so. When asked to describe what was inside the spout. She stated, It had lots of lime and dust particles. She was asked who uses the ice from the machine. She stated, The CNAs (Certified Nursing Assistants) use it to fill beverages served to the residents at meal. 5. On [DATE] at 11:45 a.m., the Ice machine in a room on 200 Hall had an accumulation of orange, black, brown and rust color residues on the right-side corner of the panel. The Dietary Supervisor was asked to wipe orange, black, brown and rust color residues on the panel. She did so, and the substance easily transferred to the tissue. She was asked to describe the residue on the ice machine panel she stated, It was orange slimy residue and was dirty. She was asked how often you clean it and who uses the ice from the ice machine. She stated, The housekeeping supposed to clean it. That's the ice the CNAs use for the water pitchers in the residents' rooms. At 4:47 p.m., Housekeeping #1 was asked how often you clean the ice machine. She stated, Once a month. I cleaned it out today. She stated, It was dirty and had a little bit of brown/rusty and black matter on the right side of the panel. 6. On [DATE] at 11:55 a.m., Dietary Employee #1 pushed the plate warmer close to the steam table and unplugged it out from the wall. She picked up tray cards and placed them on the trays. Without washing her hands, she picked up plates to be used in serving lunch meal with her fingers inside the plates, then picked up bowls with her fingers inside of them to be used in serving meal. 7. On [DATE] at 12:12 p.m., while on the serving line, Dietary Employee #1 picked up empty alcohol packages and threw them away. Without washing her hands, she picked up tray cards and placed them on the tray, picked up plates and bowls to be used in serving lunch meal to the residents and placed them on the tray with

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045148	A. BUILDING _____ B. WING _____	**07/02/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CAVE CITY NURSING HOME INC	**442 TAYLOR CIRCLE CAVE CITY, AR 72521**

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

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F 0812 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Many	(continued... from page 4) her fingers inside of them. 8. On [DATE] at 1:06 p.m., Dietary Employee #2 removed onions from the storage room and placed them on the counter. She peeled the skin off and without rinsing off the onions, she sliced the onions and placed them in a bowl. She covered the bowl with a piece of plastic wrap and placed it on a shelf in the refrigerator to be served to the residents for supper meal. 9. On [DATE] at 3:26 p.m., Dietary Employee #3 pushed a cart out of the way. She opened the refrigerator door and placed cups that contained beverages on a shelf. Without washing her hands, she picked up other cups that contained beverages to be served to the residents at supper meal by their rims and placed them on a shelf in the refrigerator. Dietary Employee #3 was asked what you should have done after touching dirty object before handling clean equipment. She stated I should have washed my hands. 10. On [DATE] at 3:51 p.m., Dietary Employee #2 turned the faucet of the sink on and obtained water in a glass and laid it on the counter. She then turned off the sink faucet with her bare hand. Without washing her hands, she picked up a clean blade and attached the blade to the base of the blender, which was used to puree food to be served to the residents who received pureed diets. when she was ready to put hamburger meat in the blade. The Surveyor asked her what you should have done after touching dirty object before handling clean equipment. She stated I should have washed my hands, still used it to puree food items. 11. On [DATE] at 12:09 p.m., the following items stored in the refrigerator in the activity room on 200 Hall were: a. There was a 22 ounce (oz) bottle of chocolate syrup on a shelf in the refrigerator with an expiration date of [DATE]. b. There was a bottle of sugar free chocolate flavored syrup on a shelf with best by date of [DATE]. c. A bag of craisins dried cranberries in the refrigerator with an expiration date of 5/ ,[DATE]. d. There was an 18.5 oz bottle of lite syrup [MEDICATION NAME] chocolate flavor with an expiration date of ,[DATE]. e. A 12.4 oz tube of cinnamon rolls was in the refrigerator with an expiration date of [DATE]. f. A 12 oz bottle of fresh and creamy taste squeeze was in the refrigerator with sell by date of [DATE]. g. A rubber container of cheese dip documented, Use by [DATE].