STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045212	A. BUILDING _____ B. WING _____	08/05/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
THE WATERS OF ROGERS, LLC	1513 SOUTH DIXIELAND RD ROGERS, AR 72758

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0583 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**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 provide appropriate accommodations and privacy for residents who tested positive for COVID-19, to sustain an environment that humanizes and promotes each residents well-being and feelings of self-worth for 1 (Resident #2) of 4 (Residents #1, #2, #6, and #7) case mix residents who had been, or were residing on, the makeshift COVID-19 (Red Zone) Unit which was located on the previous Men's Secure Unit, B Hall South. This failed practice had the potential to affect all 11 residents who currently resided on the COVID-19 Unit, according to the Facility's Resident List Report provided by the Administrator on 7/24/2020. The findings are: 1. Resident #2 had [DIAGNOSES REDACTED]. The Quarterly Minimum Data Set with an Assessment Reference Date of 7/24/2020 documented the resident scored 11 (8-12 indicates moderate cognitive impairment) on a Brief Interview for Mental Status and required extensive assistance with transfers and toileting needs. a. On 7/24/2020 at 1:00 p.m., Resident #2 was lying in bed in her room which was shared with another female resident. The room was previously the Dining Area prior to being converted into the Red Zone for positive COVID-19 residents. Registered Nurse (RN) #1 was also present during room observations. Resident #2 and the other female resident did not have any call bells on their bedside tables. Resident #2 did have a call light outlet on the wall but did not have the call light cord attached in the outlet. The resident's room did not have any privacy curtains. b. On 7/24/2020 at 1:10 p.m., RN #1 was asked, When were the two residents placed in the room together? RN #1 stated, They were placed back there on 7/23/2020. RN #1 was asked, Can (Resident #2) use a call light? RN #1 stated, Yes. I know she has in the past. RN #1 was asked, Does the resident's room have privacy curtains? RN #1 stated, No. c. On 7/24/2020 at 1:30 p.m., the Administrator was asked, Have you obtained approval from the State to designate specific rooms to accommodate COVID-19 positive residents? The Administrator stated, No.
F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Complaint # (AR 199) was substantiated, all or in part, with these findings: Based on observation, record review, and interview, the facility failed to follow up on COVID-19 lab results to ensure guidelines related to COVID-19 were followed for a resident with presumptive symptoms on the yellow precautionary hall; and failed to identify a positive COVID-19 test in a timely manner to prevent the transfer of a resident with presumptive symptoms to a hallway with presumed negative COVID-19 residents for 1 (Resident #8) of 8 case mix residents. The facility also failed to properly screen staff and designate thermometers for staff and residents on the COVID-19 positive hall to prevent potential cross-contamination and transmission of infection. These failed practices had the potential to affect all 74 residents who resided in the facility, according to the Daily Census Report provided by the Administrator on 7/24/2020. The findings are: 1. Resident #8 had [DIAGNOSES REDACTED]. The Quarterly Minimum Data Set with an Assessment Reference Date of 7/8/2020 documented the resident was severely impaired in cognitive skills for daily decision making per a Staff Assessment for Mental Status and required one-person physical assistance with transfers and toileting needs. a. The Nurses Noted dated 6/30/2020 at 7:25 a.m. documented, .Resident noted to be running a fever of 100.2 and states that he is not feeling well. Scheduled Tylenol administered. MD (Medical Doctor) notified with new orders for COVID test, CBC (complete blood count), BMP (Basic Metabolic Panel), and 2-view chest x-ray . b. A Nurses Note dated 7/1/2020 at 12:56 a.m. documented, .Receiving skilled therapies and nursing services as follows: .On COVID yellow isolation precautionary hall. Has ran a low-grade temp (temperature) lately and has COVID test results pending at this time. CXR (chest x-ray) and COVID testing ordered on 6/30 (6/30/2020). No c/o's (complaints of) or s/s (signs or symptoms) of acute respiratory distress, SOB (shortness of breath) or coughing. 02 (oxygen) sats (saturation) 98% on room Air. Low grade fever this shift, Temp 99.3. Tylenol given PO (by mouth). All other Vitals (vital signs) WNLs (within normal limits). Monitored every 4 hours. Resident checked on frequently for wants / needs. PO (oral) fluids encouraged. No acute distress noted. Call light and H20 (water) in reach at all times . c. A Nurses Note dated 7/1/2020 at 06:03 (6:03 a.m.) documented, .Tylenol Tablet 325 MG (milligrams) . Give 2 tablet by mouth every 6 hours as needed for Pain PRN (as needed) . Administration was: Ineffective . Follow-up Pain Scale was: 0 . Temp (temperature) remains 99.3 after Tylenol . d. A Nurses Note dated 7/2/2020 at 12:53 a.m. documented, .Ambulates via W/C (wheelchair). Toilets with staff assist (assistance). On COVID yellow isolation precautionary hall. Has ran a low-grade temp (temperature) lately and has COVID test results pending at this time. No acute distress noted. No c/o's (complaints) or s/s (signs and symptoms) of respiratory distress, SOB (shortness of breath) or coughing. Temp (temperature) 99.6. Tylenol given PO (by mouth). Other Vitals (vital signs) WNLs (within normal limits), monitored every 4 hours. Resident checked on frequently for wants / needs. Has insisted on spending much of the shift sitting up in W/C (wheelchair). PO (by mouth) fluids encouraged . e. A Nurses Note dated 7/2/2020 at 5:28 a.m. documented, .Tylenol Tablet 325 MG (milligrams) . Give 2 tablets by mouth every 6 hours as needed for Pain . Follow-up Pain Scale was: 0 . PRN (as needed) Administration was Ineffective. Temp (temperature) still 99.0; was 99.6, barely helped . f. A Nurses Note dated 7/3/2020 at 3:00 a.m. documented, .Tylenol Tablet 325 MG (milligrams) . Give 2 tablets by mouth every 6 hours as needed for Pain. Temp (Temperature) 100.5 . g. A Nurses Note dated 7/3/2020 at 5:13 a.m. documented, .Tylenol Tablet 325 MG (milligrams) . Give 2 tablets by mouth every 6 hours as needed for Pain PRN (as needed) . Administration was: Ineffective . Temp (Temperature) 100.5 . h. A Nurses Note dated 7/3/2020 documented, .Temp (Temperature) decreased from 100.5 to 98.9 after removing comforter and covering with a sheet and removing long sleeve shirt and replacing with a gown in addition to Tylenol given at 0300 (3:00 a.m.). Other intervention appear to be more effective than the Tylenol, or the Tylenol had a delayed response time . i. A Nurses Note dated 7/6/ 0 at 1:44 p.m. documented, .Resident is alert and oriented (times) 2. Able to express needs to staff. (Times) 1 assist (assistance) with transfers and showers. Independent on bed mobility. Feeds self after tray set-up. CBG (capillary blood glucose) daily with meals. Receives insulin daily as ordered and per sliding scale. Continues to be on A-Hall for COVID precautions. Continues to run low grade fever this morning, but after scheduled medications, temp (temperature) went down 98.2. No cough, sore throat, or SOB (shortness of breath) noted. Denies pain or discomfort at this time. Will continue to observe . j. A Nurses Note dated 7/7/2020 at 12:01 a.m. documented, .Resident continent of B & B (bowel and bladder). Assist (assistance) of 1 for ADLs (activities of daily living). Ambulates via W/C (wheelchair). Toilets with staff assist. On COVID yellow isolation precautionary hall. Has ran a low-grade temp (temperature) lately and has COVID test results pending at this time. No acute distress noted. No c/o's (complaints) or s/s (signs / symptoms) of respiratory distress, SOB (shortness of breath) or coughing. Afebrile this shift. Vitals WNLs (within normal limits). Vitals monitored every 4 hours and res (resident) checked on frequently for wants / needs. Res continues to not feel well. Awaiting COVID test results. Continues to wait COVID test results . k. A Nurses Note dated 7/7/2020 at 3:01 p.m. documented, .Resident is alert and oriented (times) 2. Able to voice wants and needs. Cont (continues) on iso (isolation) for COVID precautions. Cont (continues) to run low grade fever this morning, but after scheduled meds (medications) adm (administered) temp (temperature) went down to 97.3. No cough or SOB (shortness of breath) noted. Incont (incontinent) of B/B (bowel and bladder). Pericare q2h (every 2 hours) / prn (as needed) per staff. Assist (assistance)

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 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 1) (times) 1 with transfers and showers. Indep (Independent) with bed mobility. Feeds self after tray setup. Takes meds (medications) crushed in pudding . l. A Nurses Note dated 7/8/2020 at 2:18 p.m. documented, .On COVID yellow isolation precautionary hall. Has ran a low-grade temp (temperature) lately and has COVID test results pending at this time. No acute distress noted. No c/o's (complaints) or s/s (signs / symptoms) of respiratory distress, SOB (shortness of breath) or coughing. Afebrile this shift. Vitals WNLs (within normal limits). Vitals monitored every 4 hours and res (resident) checked on frequently for wants / needs. Res continues to not feel well. Awaiting COVID test results. Continues to await COVID test results . m. The Lab Report dated as collected 7/8/2020 and reported on 7/9/2020 documented, . COVID results collected 7/8/2020 . Reported 7/9/2020 . Negative . n. The Lab Report dated as collected 7/8/2020 and reported on 7/10/2020 documented, .COVID results collected 7/8/2020 .Reported 7/10/2020 . Positive . o. A Nurses Note dated 7/10/2020 at 11:44 p.m. documented, .Was on COVID yellow isolation precautionary hall. Just returned to regular population hall. No acute distress noted. No c/o's (complaints) or s/s (sings / symptoms) of respiratory distress, SOB (shortness of breath) or coughing. Afebrile this shift. Vitals WNLs (within normal limits). Res (resident) checked on frequently for wants / needs. Res bowel and bladder function has declined to incontinent, instead of toileting with staff assist . p. A Nurses Note dated 7/11/2020 at 9:25 p.m. documented, .Consumed less than 25% of previous meal. Resident has been taking smalls bites of food and snacks throughout the day. Fluids have been encouraged and taken fair . q. A Nurses Note dated 7/13/2020 at 12:09 p.m. documented, .Resident moved to A-Hall for COVID precautions. Resident noted to be lethargic this shift. APN (Advanced Practice Nurse) in facility and aware. Remains afebrile. Fluids continue to be encouraged. Pending CBC (complete blood count) and BMP (basic metabolic panel) results. Denies pain or discomfort at this time. Will continue to observe . r. A Nurses Note dated 7/13/2020 at 1:34 p.m. documented, .Resident noted to be lethargic. Continues to consume less than 25% of meals. Cough noted. APN in facility and new order received for CBC, BMP, COVID test. Family notified and voiced understanding. Resident moved to A-Hall for COVID precautions . s. A Nurses Note dated 7/15/2020 at 11:23 p.m. documented .Spoke with spouse, (Name) multiple times this AM (morning) regarding resident's condition . Pending COVID test result . t. A Nurses Note dated 7/15/2020 at 1:00 p.m. documented, .This nurse was notified by ADON (Assistant Director of Nursing (ADON) re (regarding) res (resident) not breathing. This nurse checked resident. No pulse noted. Not responding to verbal stimulation . u. The Lab Reports dated as collected 7/13/2020 and reported on 7/16/2020 documented, COVID results collected 7/13/2020 . Reported 7/16/2020 . Positive . v. On 8/3/2020 at 10:20 a.m., Licensed Practical Nurse (LPN) #1 was asked if she obtained the COVID-19 test results for Resident #8 on 6/30/2020. LPN #1 stated, No, I'm pretty sure the ADON (Assistant Director of Nursing) did. She was in charge of infection control before she went on maternity leave. LPN #1 was asked about Resident #8's physical condition during this time. LPN #1 stated, All the staff that took care of (Resident #8), including me, suspected that he had COVID-19. He just wasn't the same. He ran a low-grade temperature almost the whole time. We gave him Tylenol and his temperature would usually come down a little. He was visibly sick, and this was reported to our supervisors. He didn't really have a cough until right before he passed away. He was lethargic and he wouldn't really eat very much. LPN #1 was asked, Did you know why the facility staff moved the resident to the Green Zone on 7/10/2020? LPN #1 stated, I was told that he had a negative test. I think he was afebrile at that time, but he still was not the same. He didn't really want to get out of bed. LPN #1 was asked, Why did the facility wait eight days before repeating (Resident #8's) COVID-19 test? LPN #1 stated, I couldn't tell you that. I was told they were still waiting for results. w. On 8/4/2020 at 10:40 a.m., the Administrator was asked, Did the facility test (Resident #8) for COVID-19 on 6/30/2020? The Administrator stated, As far as I know (ADON) did. She was doing all the testing before she went on maternity leave. We were told that the lab (laboratory) lost the results. This has happened before and sometimes we do not get the test results back for up to a week. The Administrator was asked, Why did they move (Resident #8) off of the Yellow Zone on 7/10/2020? The Administrator stated, We got (Resident #8's) negative test results on Friday (7/10/2020). So, we moved him to the Green Zone. We did not receive the positive results until the following Monday (7/13/2020). The Administrator was asked, Why did she receive two different laboratory results on two different days (7/9/2020 and 7/10/2020)? The Administrator stated, I don't know for sure. You would have to ask the lab (laboratory). We suspected that the lab got the results mixed up with another resident. 2. On 7/24/2020 at 1:05 p.m., the following observations were made on the COVID-19 Positive Unit with Registered Nurse (RN) #1: The COVID-19 Unit was located on the previous Men's Secure Unit, B Hall South. The COVID-19 Positive Hall currently had 11 COVID-19 positive residents residing on this hallway / Unit. The COVID-19 positive hall / unit had 11 rooms dedicated to residents including the 2 rooms that were previously the Dining Area and Day Area prior to the COVID-19 Pandemic. The Nurses Station / Lounge was located in room [ROOM NUMBER] which was located at the end of the hallway on the right side. The only way to enter the COVID-19 positive hallway / unit was from the outside according to facility staff interviewed. The entrance was partitioned off with clear, plastic sheeting. The Clean Room, or partitioned area, contained a plastic cabinet with three drawers. The drawers contained an assortment of Personal Protective Equipment (PPE). The partitioned area (Clean Zone) was approximately 4 feet by 8 feet. This room was supposed to be dedicated for staff to put on PPEs, sanitize hands, take temperatures, and fill out COVID-19 screening prior to entering COVID-19 positive hallway / unit. The Clean Zone did not have any Alcohol Based Hand Sanitizer, thermometer, or COVID-19 Screener log dedicated to this room. a. On 7/24/2020 at 1:10 p.m., RN #1 was asked, Where is the Alcohol Based Hand Sanitizer (ABHS) dedicated to the Clean Zone located? RN #1 stated, We have ABHS devices located on the walls in the hallway and the staff are provided with ABHS they can put in their pockets. RN #1 was asked, Where is the thermometer for staff to take their temperatures prior to coming onto the COVID-19 positive hall / unit? RN #1 stated, I don't know. It is supposed to be back here. I will have to check. RN #1 was asked, Is there a staff member back here on the COVID-19 positive unit / hall that screens staff before they are allowed to come back on the COVID-19 positive unit / hallway? RN #1 stated, Yes. The staff are usually screened by the Licensed Practical Nurse (LPN) prior to coming back on the unit. I do not know why the screening log is not back here. I will have to check. b. On 7/24/2020 at 1:15 p.m., Certified Nursing Assistant (CNA) #1 was asked, How are you screened prior to coming on the COVID-19 positive unit / hall? CNA #1 stated, I go down the hallway and do my screening in the lounge. I do it myself. The screening book is in the lounge. Sometimes, the thermometer is up front when you enter the COVID unit. It is in the top drawer where you find the gowns. I guess staff just carry them off. The screening log is usually in the nursing station. c. On 7/28/2020 at 11:50 a.m., CNA #2 was asked, How does the screening process work back on the COVID-19 positive unit / hall? CNA #2 stated, The screening book was back in the Nurses Station along with the thermometer. I gowned up and went straight to the Nurses Office and did my screening. I didn't go into anybody's room. The screening book and thermometer have been up front (Clean Zone), but somebody keeps moving it. I don't know who. CNA #2 was asked if they had a thermometer dedicated to the residents, and one dedicated to the staff? CNA #2 stated, We have two thermometers, but we usually use for both patients and staff. They are the ones you hold close to your head and it will give you a reading. You do not have to touch your head or the resident's head. We clean them off with alcohol pads after using them. A lot of times the battery will be dead on one of them so we will have to use the other. It just depends. I don't know where the batteries are at. Nobody has told me. d. On 7/28/2020 at 10:15 a.m., Registered Nurse (RN) #2 was asked, Is anybody screening the staff for COVID-19 symptoms and checking temperatures prior to them working on the COVID-19 positive unit / hallway? RN #2 stated, We screen ourselves. RN #1 was asked, Where is the COVID-19 Screening Log and thermometer located for staff to utilize prior to coming to work on the COVID-19 positive hall / unit? RN #2 stated, I'm not going to lie you. Sometimes the Screening Log and thermometer are located up front in the Clean Zone and sometimes you can find them in the Nurse's Station. All the staff gown up in the Clean Zone prior to coming back on the hallway. The first day I worked back here I had to ask where the thermometer was. The batteries were dead. We have two thermometers, one of those infrared ones and a temporal thermometer. We don't have a thermometer dedicated for just the residents. e. On 8/4/2020 at 8:35 a.m., Licensed Practical Nurse (LPN) #2 was asked, Is anybody screening the staff for COVID-19 symptoms and checking temperatures prior to them working on the COVID-19 positive unit / hallway? LPN #2 stated, Nobody is screening staff. They do it themselves. We have no set person to do that. We do review the Screening Logs. They are supposed to take their temperature, check oxygen saturation, and log in. The Screening Log and thermometer are supposed to be on the Clean Zone so the staff can check before gowning up and entering the COVID Hall. It doesn't always happen that way.
F 0919 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Make sure that a working call system is available in each resident's bathroom and bathing area.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**

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F 0919 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 2) Based on observation and interview, the facility failed to provide a communication system which relayed the call directly to a staff member or to a centralized staff work area to allow residents to call for staff assistance for 2 (Resident's #3 and #4) of 5 (Residents #3, #4, #6, #7, and #5) case mix residents. This failed practice had the potential to affect all 74 residents who were or had the potential to be transferred to rooms related to the COVID-19 Pandemic that had not been adequately furnished with a functioning communication system to allow for residents to call for assistance. The findings are: 1. Resident #3 had [DIAGNOSES REDACTED]. The Quarterly Minimum Data Set with an Assessment Reference Date of 7/22/2020 documented the resident scored 14 (13-15 indicates cognitively intact) on a Brief Interview for Mental Status and required extensive assistance with transfers and toileting needs. a. On 7/24/2020 at 12:09 p.m., Resident #3 was lying in Bed A (closest to the door) in room [ROOM NUMBER] on the A side. The A side had been converted into a (Yellow Zone). The Yellow Zone was designed to accommodate new admissions, re-admissions, residents who were transferred to [MEDICAL TREATMENT] facilities, and wound care clinics on a weekly basis, and residents who had COVID-19 related symptoms but had not tested positive for COVID-19. The facility staff were supposed to be wearing gowns, gloves, and N-95 related masks to care for these residents. The Yellow Zone was partitioned off with a clear, plastic sheeting which had zippers to enter and exit. The room prior to the COVID-19 Pandemic was a conference room. The A side had been dedicated for COVID-19 positive residents (Red Zone) from 5/28/2020 to 6/10/2020. The Red Zone had been moved to the Men's Secure Unit on South B Hall due to the increased number of positive COVID-19 residents in the facility. The room had no call light system. The resident had been provided with a call bell that was sitting on his bed side table. b. On 7/24/2020 at 12:15 p.m., Resident #3 was asked, How do you alert the facility staff if you need assistance? Resident #3 stated, I call them at night. I have my phone. The call lights don't work. They haven't worked for a while. This call bell works when they have staff back here all the time. There is nobody on the Yellow Hall at night. They have a Certified Nursing Assistant (CNA) working on different halls at night. They don't answer the phone at night or sometimes it takes forever for them to get over here. I have had to wait over an hour for somebody to come in here. They are wearing the CNAs out. c. On 7/28/2020 at 11:02 a.m., the Maintenance Assistant was asked, Why are the call lights not working in room [ROOM NUMBER] on the A side in the Yellow Zone? The Maintenance Assistant stated, It is a wiring situation. The residents were provided with call bells. 2. Resident #4 had [DIAGNOSES REDACTED]. The Quarterly Minimum Data Set with an Assessment Reference Date of 5/12/2020 documented the resident scored 15 (13-15 indicates cognitively intact) on a Brief Interview for Mental Status and required extensive assistance with transfers and toileting needs. a. On 7/24/2020 at 12:09 p.m., Resident #4 was lying in Bed B (closest to the window) in room [ROOM NUMBER] on the A side. The A side had been converted into a Yellow Zone. The room, prior to the COVID-19 Pandemic, was a conference room. The room had no call light system. The resident had been provided with a call bell that was sitting on his bedside table. b. On 7/24/2020 at 12:18 p.m., Resident #4 was asked, How do you alert the facility staff if you need assistance? Resident #4 stated, I use my call bell. They are usually pretty good during the day. It is at night when we have problems. Sometimes we have to call on our phones to get any help back here. Sometimes they don't even answer, so we just have to wait. I don't have any legs so not much that I can do. We have never had any call lights in this room.