STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045245	A. BUILDING _____ B. WING _____	08/28/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CONWAY HEALTHCARE AND REHABILITATION CENTER	2603 DAVE WARD DRIVE CONWAY, AR 72034

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 helped a resident have a private area to have a conversation with family and staff did not discuss residents medical condition out in the hall to promote dignity for 1 (Resident #58) of 1 (Residents #58) case mix residents who received a facetime call in the hallway. The facility also failed to ensure a urinary catheter bag was concealed in a privacy bag for 2 (Residents #44 and #49) who had a urinary catheter. The findings are: 1. Resident #58 had a [DIAGNOSES REDACTED]. The quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 06/19/2020 documented the resident scored 13 (13 to 15 indicates cognitively intact) per a Brief Interview of Mental Status (BIMS) and required extensive assist of two people for bed mobility and transfers. a. On 08/24/2020 at 1:28 P.M., Resident #58 was sitting in the hallway on the 300 hall face timing on an iPad with family. The Treatment Nurse walked up to inform the family that his pressure ulcer on his bottom was improving. b. On 08/24/2020 at 1:37 P.M., the Social Director was asked, Is this the only place that residents have to face time with their families? She stated, No, sometimes it's in their room. She was asked, Should personal information be discussed in the hallways? She stated, No. c. On 08/24/2020 at 2:00 P.M., the Treatment Nurse was asked, Should you have been telling family out in the hallway about (Resident #58's) pressure ulcer? She stated, No. 2. Resident #44 had [DIAGNOSES REDACTED]. The Admission MDS with an ARD of 07/21/2020 documented the resident scored 13 (13 to 15 indicates cognitively intact) per a BIMS and required extensive assist of two people for bed mobility and transfers. a. On 08/24/2020 at 10:48 A.M., Resident #44's catheter bag was hanging on the side of the bed with no privacy bag and was visible from the hallway. 3. Resident #49 had [DIAGNOSES REDACTED]. The Quarterly MDS with an ARD of 07/13/2020 documented the resident scored 15 (13 to 15 indicates cognitively intact) per a BIMS. Resident requires limited assist of one person for bed mobility and transfers. a. On 08/24/2020 at 10:48 A.M., Resident #49's catheter bag was hanging on the side of the bed with no privacy bag and was visible from the hallway. b. On 08/24/2020 at 11:00 A.M., the Director of Nursing was asked, Should the catheter bag be covered, or at least not hanging where it can be seen from the doorway? She stated, I just got new bags in.
F 0554 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Allow residents to self-administer drugs if determined clinically appropriate.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure a resident was not allowed to self-administer medications, before an assessment was conducted to determine if this practice was safe, to prevent potential complications and errors for 1 (Resident #33) of 10 (Residents #15, #11, #62, #7, #58, #44, #49, #33, #51, and #19) sampled residents. This failed practice had the potential to effect 23 total residents in the facility who received eye drops, based on a list provided by the Infection Control Nurse on 08/28/2020. The findings are: 1. Resident #33 had a [DIAGNOSES REDACTED]. a. The August 2020 physician orders [REDACTED]. b. On 08/27/2020 at 8:22 a.m., Licensed Practical Nurse (LPN) #6, entered Resident #33's room and administered Resident #33's oral medications and then handed him his eye drops ([MEDICATION NAME] 0.5%) and the resident self-administered 1 drop in both eyes. c. There was no documentation in the medical records regarding the self-administration of medication. d. On 08/27/2020 at 10:00 a.m., LPN #6 was asked if the resident had a self-administration assessment. She replied No, he did not.
F 0558 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Reasonably accommodate the needs and preferences of each resident.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interview the facility failed to ensure the call light was in reach for two (Residents #6 and #59) sampled residents and failed to ensure 1 (Resident #18) was positioned in a Broda chair to prevent her feet from touching the floor or resting on a footrest. These failed practices had the potential to affect 74 residents residing in the facility per the Residents Census by Hall provided by the Administrator on 08/24/2020 and 44 residents who were in a chair all or most of the time per the Resident Census and Conditions of Residents provided by the Administrator on 08/25/2020. The findings are: 1. Resident #6 had [DIAGNOSES REDACTED]. The Annual Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 06/04/2020 documented the resident was severely impaired in Cognitive Skills for Daily Decision Making (SAMS) and required extensive to total assistance of one to two staff for activities of daily living. a. On 08/24/2020 at 10:48 A.M., Resident #6 was sitting up in a Geri chair with the call light on the bed, out of reach of the resident. b. On 08/26/2020 at 11:19 A.M., the Director of Nursing (DON) was asked if (Resident #6) was able to use the call light if it was close enough to her. She replied, I believe she could. She was asked if she could possibly reach it with it being over on the bed. She replied, No, 2. Resident #59 had [DIAGNOSES REDACTED]. The Quarterly MDS with an ARD of 08/07/2020 documented the resident was severely impaired in Cognitive Skills for Daily Decision Making (SAMS) and required extensive to total assistance of one - two staff for activities of daily living. a. On 08/24/2020 at 11:55 A.M., Resident #59 was lying in bed on her right side with her eyes closed. The call light was above her head on the other side of the pillow out of reach. b. On 08/25/2020 at 9:15 A.M., Resident #59 was lying in bed on her back with her eyes open and the call light was on the right upper side of the bed above her head out of reach. c. On 08/28/2020 at 11:30 A.M., the DON was asked if (Resident #59) could use her call light if it were in her reach. She replied, Yes. 3. Resident #18 had a [DIAGNOSES REDACTED]. The Quarterly MDS assessment with an ARD of 06/12/2020 documented the resident was severely impaired in Cognitive Skills for Daily Decision Making (SAMS) and required extensive assistance of one to two plus persons for all ADL's and was totally dependent for bathing. a. On 08/24/2020 at 12:05 P.M., the resident was sitting in Broda chair, dangling her feet, unable to reach floor (picture taken at this time). b. On 08/27/2020 at 8:15 A.M., the resident was being assisted from the dining room in her Broda chair with her feet dangling from the chair and unable to touch the floor. c. On 08/28/2020 at 10:20 A.M., the DON was asked if a resident should be positioned in a chair as to where her feet cannot touch the floor or be on foot pedals. She replied, No they should not.
F 0567 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Honor the resident's right to manage his or her financial affairs.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview the facility failed to ensure funds were readily accessible for 4 (Residents #35, #43, #49 and #62) of 11 (Residents #6, #7, #11, #19, #23, #35, #43, #47, #49, #51, and #59) sampled residents whose personal funds were managed by the facility. This failed practice had the potential to affect 66 residents residing in the facility whose Personal Funds were managed by the facility. The findings are: 1. Resident #35 had [DIAGNOSES REDACTED]. The Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 07/09/2020 documented the resident scored 14 (13 - 15 indicates cognitively intact) per a Brief Interview of Mental Status (BIMS). On 08/25/2020 at 8:34 A.M., Resident

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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CONWAY HEALTHCARE AND REHABILITATION CENTER	**2603 DAVE WARD DRIVE CONWAY, AR 72034**

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F 0567 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 1) #35 was asked if she had ready access to her personal funds managed by the facility. She said, If I need it, just not on the weekends. 2. Resident #62 had [DIAGNOSES REDACTED]. On 08/25/2020 at 8:53 A.M., Resident #62 was asked if he had ready access to his personal funds managed by the facility. He said, I can get it Monday thru Friday. 3. Resident #43 had [DIAGNOSES REDACTED]. The Annual MDS with an ARD of 07/17/2020 documented the resident scored 15 (13 - 15 indicates cognitively intact) per a BIMS. On 08/25/2020 at 9:02 A.M., Resident #43 was asked if she had ready access to her personal funds managed by the facility. She said, I've never asked for money on the weekend because I know I can't get any money on the weekends, because the lady who handles that doesn't work on the weekends or after 4:00 P.M. and before 8:00 A.M. through the week and no one can get me my money in her absence. 4. Resident #49 had [DIAGNOSES REDACTED]. The Quarterly MDS with an ARD of 07/30/2020 documented the resident scored 15 (13 - 15 indicates cognitively intact) per a BIMS. On 08/25/2020 at 9:25 A.M., Resident #49 was asked if he had ready access to his personal funds managed by the facility. He said, We can get money during the day during the week. 5. On 08/25/2020 at 4:20 P.M., the Business Office Manager was asked if the residents have ready access to money managed by the facility on the weekends. She said, No, I am not here on the weekends and no one gives out their money but me.
F 0570 **Level of harm** - Potential for minimal harm **Residents Affected** - Many	**Assure the security of all personal funds of residents deposited with the facility.** Based on record review and interview the facility failed to ensure that their Surety Bond was in an amount sufficient to cover the total amount of all Resident Personal Funds. This failed practice had the potential to affect 66 Residents whom the facility manages their Personal Funds. The findings are: 1. The Trust Account Balance Report provided by the Business Office Manager (BOM) on 08/25/2020 at 4:28 P.M. documented a total of $55,931.17. 2. The Surety Bond Continuation Certificate provided by the BOM on 08/25/2020 at 4:38 P.M., documented, Bond No. (Number) .Principal: .Bond Amount: $35,000.00 .Bond Description: Patient Trust Funds Bond .effective from: September 1, 2019 until August 31, 2020. Signed by the Administrator on August 14, 2019. 3. An Email from the (Regional Business Office Consultant #1) regarding the Surety Bond dated 06/01/2020 documented, .we know that you will all most likely be over your Surety Bond amount due to the receipt of the stimulus checks. (Regional Business Office Consultant #2) is working on this issue with AHCA (American Health Care Association) and will advise once he receives an answer . 4. As of 08/28/2020 at 4:29 P.M., the facility had not provided a Surety Bond sufficient to cover Resident Personal Funds in the amount of $55,931.17.
F 0657 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**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 a newly admitted resident's care plan included isolation for 14 days after admission to prevent the potential spread of the Coronavirus for 1 (Resident #222) of 2 (#51 and #222) sampled residents. This failed practice had the potential to affect 4 newly admitted residents within the past 30 days based on a list provided by the Administrator on 08/24/2020. The findings are: Resident #222 was admitted to the facility on [DATE] and had [DIAGNOSES REDACTED]. The Admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 08/25/2020 documented the resident was moderately impaired in Cognitive Skills for Daily Decision Making (SAMS) and required extensive assistance of 2 plus person assistance for dressing and toileting and 1 person assistance for eating and personal hygiene. a. The August 2020 physician's orders [REDACTED]. with a start date of 08/20/2020. b. The care plan with a revision date of 08/25/2020 contained no documentation related to COVID-19 or isolation precautions.
F 0695 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**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 was administered at the flow rate ordered by the physician to reduce the potential for complications for 1 (Resident # 71) of 4 (Residents #19, #44, #59, #71) sampled residents who had physician orders [REDACTED]. The findings are: Resident #71 had [DIAGNOSES REDACTED]. The Minimum Data Set with an Assessment Reference Date of 08/18/2020 indicates resident scored 15 (13-15 indicates cognitively intact) on Brief Interview of Mental Status and required extensive assist of two persons for bed mobility, transfers and toileting. a. A Physician order [REDACTED]. b. The Plan of Care with a revision date of 08/19/2020 documented, .Use O2 (Oxygen) 2 l (liters) n/c. (nasal cannula) . c. On 08/24/2020 at 10:48 A.M., Resident #71's Oxygen was set on 1 liters via (by way of) nasal cannula via a concentrator located beside the resident's bed. d. On 08/25/2020 at 9:24 A.M., Resident # 71's Oxygen was set on 1 liters via nasal cannula via a concentrator located beside the resident's bed. e. On 08/26/2020 at 8:20 A.M., Resident # 71's Oxygen was set on 1 liters via nasal cannula via a concentrator located beside the resident's bed. f. On 08/26/2020 at 9:11 A.M., the Director of Nursing was asked, Can you tell me what the Resident # 71's oxygen concentrator is set at? She glanced at the concentrator and stated, 1. She was asked, Can you get eye level with it and tell me what it is set at? She stated, 1. She was asked, What is the order for this resident? She stated, I don't know. She was asked, How often is the concentrator checked for correct settings? She stated, I will look.

F 0697 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Provide safe, appropriate pain management for a resident who requires such services.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interview the facility failed to ensure the physician was notified of complaints of pain so pain relieving medication could be promptly ordered and administered for 1 (Resident #43) of 14 (Resident #6, #7, #11, #17, #18, #19, #43, #44, #49, #51, #61, #67, #71, and #222) sampled residents who complained of pain. This failed practice had the potential to affect 57 Residents who had orders for pain medication per a list provided by the DON on 08/28/2020 and The findings are: Resident #43 had [DIAGNOSES REDACTED]. The Annual Minimum Data Set with an Assessment Reference Date of 07/17/2020 documented the resident scored 15 (13-15 indicates cognitively intact) per a Brief Interview of Mental Status and had frequent pain at 5 on a scale of 1 to 10 and had not received any opioids during the last 7 days. a. The August 2020 Physician order [REDACTED]. Order Date 07/03/2020. .[MEDICATION NAME] 50 mg i (one) po (by mouth) q (every) 6 hrs (hours) as needed for pain in BLE (Bilateral Lower Extremities) . Order date 08/25/2020. b. The August Medication Administration Record [REDACTED].M.), 1200 (12:00 P.M.) and at 1600 (4:00 P.M.) from 08/01/2020 to 08/25/2020. There was no documentation of any other pain medication administered until 08/26/2020. c. On 08/26/2020 at 0800 the August 2020 MAR indicated [REDACTED].M.). There was no documentation of [MEDICATION NAME] being administered since order date of 08/25/2020. d. The Resident Plan of Care updated on 07/17/2020 documented, .Focused: I have Chronic Pain. Dx: (diagnosis)[MEDICAL CONDITION] c (with) lt. (left) [MEDICAL CONDITION]/ (and or) [MEDICAL CONDITIONS], Dementia. Hx (history) Venous [MEDICAL CONDITION]. Take anticonvulsant and [MEDICATION NAME] medications. W/C (wheelchair) for mobility. At risk for 1) pain not controlled. Approaches: Administer pain medication as ordered/needed. Notify MD (Medical Doctor)/Practitioner if not effective. e. On 08/24/2020 at 11:45 A.M., Resident #43 was sitting in her wheelchair in her room with her eyes closed. She responded to a knock on the door and verbal stimuli. Resident #43 was asked if she has any unrelieved pain. She stated, Yes, since Friday night. I needed pain medication for my feet and legs due to [MEDICAL CONDITION] but they told me that I currently didn't have an order for [REDACTED]. On 08/24/2020 at 01:05 P.M., Resident #43 in her wheelchair in the dining room. She was asked if she had seen the doctor yet for her pain medication issue. She stated, No, not yet. She was asked if she still needed pain medication and she said, Yes. g. On 08/25/2020 at 08:53 A.M., Resident #43 in her wheelchair in her room. She was asked if she had seen the Doctor yet about her pain and pain medication. She said, No, not yet. She was asked if she was still having unrelieved pain. She said, Yes, I am. h. On 08/25/2020 at 2:50 P.M., Resident #43 was sitting in her wheelchair in her room with her eyes closed. She responded to verbal stimuli. She was asked if she had seen the Doctor yet about her pain and pain medication. She said, No, not yet, I am hoping to soon because my pain in my feet and legs is worse at night. She was asked if she was having any pain now. She said, Yes, but not as bad as it is at night. i. On 08/26/2020 at 8:25 A.M., Resident #43 was lying in bed with eyes closed and lights off. She responded to verbal stimuli. She was asked how she was doing. She said, I'm not doing very well but they finally gave me my pain medication this morning. It is a little better, but I don't feel very well today. She was asked if the doctor saw her. She said, Yes, it was the APN (Advanced Practice Nurse) who finally saw me and ordered my pain medication I received this morning. j. On 08/27/2020 at 11:40 A.M., LPN #1 stated, When I worked with her through the weekend, I was giving her her routine pain medication and she was experiencing relief from that. Her prn (as needed) pain medication was discontinued due to non-use and the last prn pain medication had been given back in June. She was able to continue her normal ADL (activities of daily living) until after she received the prn [MEDICATION NAME] the morning of

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F 0697 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 2) 08/26/2020 which made her groggy and she slept most of the day. The next morning I observed her back up in her wheelchair in the main dining room and she had eaten all of her breakfast and said that she was so much better but had slept most of the day before because of the pain medication she received. k. 08/27/2020 at 11:45 A.M., the DON stated she was told that (Resident #43) was experiencing pain relief after her routine pain medication was given throughout the weekend and through 08/25/2020 when the APN ordered the prn [MEDICATION NAME].
F 0805 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**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 meals observed. This failed practice had the potential to affect 6 residents who received pureed diets, according to the Diet list provided by Dietary Employee #1 on 08/26/2020. The findings are: 1. On 08/26/2020 at 12:08 p.m., the following observations were made on the steam table in the kitchen: a. A pan of pureed cornbread with milk was on the steam table in the kitchen. The consistency of the pureed cornbread was not smooth. There were pieces of cornbread visible in the mixture. b. A pan of pureed oven fried potatoes was on the steam table in the kitchen. The consistency of the pureed potatoes was dry and sticky. c. On 08/26/2020 at 12:34 p.m., Dietary Employee #1 (Food Service Supervisor) was asked to describe the consistency of the pureed cornbread and pureed potatoes prepared and served to the residents on pureed diets for lunch. She stated, The pureed cornbread was too thick needed a little more liquid. The pureed potatoes were thick and dry and needed a little more liquid. d. On 08/27/2020 at 8:34 a.m., Dietary Employee #4 was asked to describe the consistency of the pureed cornbread and the pureed oven fried potatoes served to the resident at the lunch meal on 08/26/2020. She stated, The pureed cornbread was a little thick, it was not that smooth. The pureed potato was a little thick and was sticky. 2. On 08/27/2020 at 7:25 a.m., the pureed sausage served to the residents on pureed diets was not smooth. There were pieces of sausage visible in the mixture. a. On 08/27/2020 at 7:30 a.m., a pan of pureed sausage was on the steam table. The mixture was not smooth. It was gritty and had pieces of sausage visible in it. b. On 08/27/2020 at 7:32 a.m., Dietary Employee #2 was asked to describe the consistency of pureed sausage served to the residents. She stated, It was not smooth and was gritty. c. On 08/27/2020 at 8:36 a.m., Dietary Employee #2 was asked to describe the consistency of pureed sausage served to the residents. She stated, It was not creamy nor smooth. It was gritty.
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.** Based on observation and interview, the facility failed to ensure food items stored in the freezer were covered or sealed and Dietary staff washed their hands before handling clean equipment or food items to decrease the potential for food borne illness for residents who received meals from 1 of 1 kitchen. These failed practices had the potential to affect 73 residents who received meals from the kitchen (total census: 74), as documented on the list provided by Dietary Employee #1 on 08/26/2020. The findings are: 1. On 08/26/2020 at 9:14 A.M., the following observations were made in the freezer: a. An open box of hamburger patties was on a shelf in the freezer. The box was not covered or sealed. b. A box of cheese enchiladas was on a shelf in the freezer. The box was not covered or sealed. 2. On 08/26/2020 at 9:16 A.M., Dietary Employee #2 with gloves on her hands, picked up a clean dish rack that had 8 partitions where forks, spoons and knives are placed with their tips down in the rack after each meal to wash. When she picked up the rack from the clean area and placed it on the counter toward the window, the tips of the forks, spoons and knives were upright. Without removing her gloves and washing her hands, she picked up the forks, spoons and knives by their tips and placed them face down in the rack. She then picked them up by their handle and wrapped in napkins for the residents to use in eating their lunch meal. Dietary Employee #2 did not rewash the utensils before wrapping them in napkins to be used by the residents. 3. On 08/26/2020 at 9:20 A.M., 9 glasses that contained ice cubes were on a tray at the bottom of the freezer where carrots and boxes of cakes were stored. The glasses were not covered or sealed exposing the ice to potential cross contamination. 4. On 08/26/2020 at 10:05 A.M., Dietary Employee #3 washed her hands and dried them with tissue paper. She used the same tissue to wipe off water around the sink. She then picked up glasses by their rims and placed them on the tray to be used in serving beverages to the residents for lunch. Dietary Employee #3 picked up boxes of nectar thickened apple juice and water from the refrigerator and laid them on the counter. Without washing her hands, she picked glasses by their rims and placed them on the tray to be used in serving beverages to the residents for the lunch meal. Dietary Employee #3 was asked, What should you have done after touching dirty objects before handling clean equipment or food items? She stated, Washed my hands. 5. On 08/26/2020 at 10:12 A.M., Dietary Employee #2 had gloves on her hands, she picked up trays from a rack and laid them on the counter. Without changing gloves, she picked up bowls from a shelf above the counter and placed them on the trays with her gloved hands touching the inside of the bowls. She took the trays that contained bowls and placed them on the counter where a pan of peach cobbler was kept. Dietary Employee #2 pulled out a drawer where scoops were stored and took out a scoop to be used in portioning dessert to be served to the residents for lunch and placed it on a pan liner on the counter contaminating the glove. Without changing gloves and washing her hands, she picked up more bowls and placed them on the tray with her fingers inside the bowls. She picked up a #8 scoop and used it to scoop peach cobbler into individual bowls to be served to the residents on regular diets. Dietary Employee #2 was asked, What should you have done after touching dirty objects before handling clean equipment or food items? She stated, I should have changed gloves and washed my hands. 6. On 08/26/2020 at 11:05 A.M., Dietary Employee # 4 took out 2 pans from the oven that contained cornbread and placed them on the counter. Without washing her hands, she picked up a clean blade and attached it to the base of the blender to be used in pureeing food items to be served to the residents on pureed diets. 7. On 08/26/2020 at 11:08 A.M., Dietary Employee #4 picked up a pan of oven fried potatoes and placed it in the oven. Without washing her hands, she placed a glove on her hand and used it to attach a clean blade at the base of the blender to be used in pureeing food items to be served to the residents on pureed diets. 8. On 08/26/2020 at 11:16 A.M., Dietary Employee #4 lifted the handle to the dish washing machine, took out a blender bowl and blade. She attached blade at the base of the blender to be used in pureeing food items. Dietary Employee #4 used 4oz (ounce) spoon to spoon 7 servings of turnip greens into a blender, she pureed and poured them into a pan. She placed a pan of pureed turnip green in the oven. On 08/27/2020 at 8:40 A.M., Dietary Employee #4 was asked, What should you have done after touching dirty objects before handling clean equipment or food items. She stated, Washed my hands.
F 0880 **Level of harm** - Immediate jeopardy **Residents Affected** - Some	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that a newly admitted resident was kept in isolation for 14 days after admission to prevent the potential spread of Coronavirus for 1 (Resident #222) of 2 (Residents #51 and #222) sampled residents who was a new admit. This failed practice resulted in Immediate Jeopardy that caused or was likely to cause serious harm, injury or death to 11 residents on the Secure Unit who were potentially exposed to the Coronavirus from Resident #222 who was a new admit and would not stay in his room in isolation. The Administrator was notified of the Immediately Jeopardy on 08/25/2020 at 3:50 P.M. The facility failed to ensure staff wore a mask at all times. This failed practice had the potential to affect all 74 residents per the Residents Census by Hall provided by the Administrator on 08/24/2020. The findings are: 1. Resident #222 was admitted to the facility on [DATE] and had [DIAGNOSES REDACTED]. The Admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 08/25/2020 documented the resident was moderately impaired in Cognitive Skills for Daily Decision Making (SAMS) and required extensive assistance of 2 plus person assistance for dressing and toileting and 1 person assistance for eating and personal hygiene. a. The August 2020 physician's orders [REDACTED]. with a start date of 08/20/2020. b. On 08/24/2020 at 12:54 p.m., Resident #222 was in his room laying on his bed. His lunch tray was delivered to his room by Certified Nursing Assistant (CNA) #2. CNA #2 walked into his room with his tray and in approximately 3-5 minutes later came out of his room. The only Personal Protective Equipment (PPE) that was observed in use was a facial mask. No isolation precautions were observed to be established by his room. c. On 08/25/2020 at 1:39 p.m., Resident #222's room, had no isolation precautions established or signage by his door

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045245	A. BUILDING _____ B. WING _____	08/28/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CONWAY HEALTHCARE AND REHABILITATION CENTER	2603 DAVE WARD DRIVE CONWAY, AR 72034

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 0880 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 3) of the need for isolation precautions. d. On 08/25/2020 at 4:50 p.m., Licensed Practical Nurse (LPN) # 5 was asked to recall the events of the day (Resident #222) was admitted to the facility? She replied, When I came into work, he was already on the 600 hall. I knew he was a new admission, so I brought it up to (BOM) who said it was ran by (Nurse Consultant). I asked them what about my residents back in the unit, he's putting them at risk, don't they matter and (LPN #2) said it was better for him to be back there. She was asked, Who initiated the transfer? She replied, The BOM, she was told to after she called the Nurse Consultant. e. On 08/26/2020 at 6:45 a.m., LPN #2 was asked Why was (Resident #222) moved to the 600 hall? She replied, He was pacing, going into other resident's rooms. We tried to redirect him, but he wouldn't be redirected. They talked to someone and said move him to 600 hall. She was asked, Were isolation precautions established when he was moved? She replied, I don't know, I wasn't working on that hall. I was working on 100 and 200 halls. f. On 08/26/2020 at 2:18 p.m., the Nurse Consultant was asked, Do are you familiar with (Resident #222)? She replied, He was the one they had admitted last Thursday. They attempted to put him on 100 hall, but he was high risk for wandering so they called me. They asked what they could do if he was that much of a risk for elopement. So, I asked them if they had a room on 600 hall at the end of the hall, at the back, so they could isolate him, and they said yes. I told them to maintain isolation precautions as much as possible, and to try to get him to wear a mask as much as possible. She was asked, Did you know they had put him at the front of 600 hall? She replied, Not until yesterday. She was asked, Who contacted you when he was admitted , and issues were discovered? She stated, the (Business Office Manager), I texted the Director of Nurses and didn't get an answer, but she called me right back. She asked where was (LPN #7), and I told her she was on vacation. She was asked, What were the determining factors for moving him? She replied, He was wandering in and out of other resident's rooms. He was an elopement risk. She was asked, Do you know if isolation precautions were established when he was moved? She replied, I was not aware that they were not set up. She was asked, Do you know who was in charge of the facility that day? She replied, (Registered Nurse (RN) #1) the Minimum Data Set (MDS) Coordinator. She was the acting RN/DON at the time since the DON wasn't here. I called the facility and talked to RN #1 and asked her why she wasn't involved with the decisions up to this point and she told me that she had been busy with a situation involving a nurse and a medication, so I covered with her the things i had already covered with the others. She was asked, When the resident was admitted , did you have any COVID test results? She replied, He came from home with his wife, and protocol is to allow an admission and to swab him upon admission if he has not been in the hospital or another facility. g. 08/26/2020 at 2:40 p.m., LPN # 5 was asked, Remind me who you said initiated the transfer. She replied, I was told by the (BOM) that that was what the Nurse Consultant said. She also said that the admission had been approved by the Admission team and she named a few people off which included the Administrator. And I asked her, So (Administrator) knows? She said yes. She was asked, When you asked them what about your residents, what did they say? She replied, (LPN #2) said there's nothing that can be done about it, what's done is done. It's better than him running around out here infecting these people. She was asked, Was there any isolation precautions established when you came to work? She replied, No isolation was set up when I came on. I got here about 2:45 p.m. and he was already on 600 hall in room [ROOM NUMBER] bed B. h. On 08/26/2020 2:46 p.m., LPN #3 was asked, Please account for me the events of 08/20/2020 and (Resident #222's) admission? She replied. When I got here, they told me he had been admitted at 10:00 a.m. that day. She was asked, Do you know why he was moved from the 100 hall to the 600 hall? She replied, He was roaming outside of his room, going into other resident's rooms. She was asked, Do you know who approved him to be transferred to another hall? She replied, (Business Office Manager) said it was OK for him to go to 600 hall. She said he could have gotten out of the facility and into the road and gotten ran over. She was asked, How did his nurse feel about him being transferred? She replied, She was upset. But (Business Office Manager) told her that corporate had okayed it. She was asked, Who was responsible for establishing isolation precautions and setting up isolation equipment? She replied, (LPN #2) on the 100 and 200 halls. (LPN #4) should have been the one responsible for setting up the isolation precautions on the 500 and 600 halls. i. On 08/26/2020 at 2:52 p.m., the Business Office Manager (BOM) was asked to recount the events of 08/20/2020 regarding the admission of (Resident #222). She reported, He was admitted from home and was put on 100 hall in isolation. He kept wandering in and out of rooms and we were concerned about his safety. So, we called the Nurse Consultant and told her what was happening. She asked if we had a room on 600 hall that we could put him in that would be a private room, that we could set up isolation and have him wear a mask, and if we did, it would be ok to move him. So, we moved him to 600 hall. To my knowledge, no isolation bins were set up. When he was on 100 hall, there was an aide on that hall and she tried to redirect him, but his wandering was constant, and he was coming out of his room and having to be redirected every 3-5 minutes. The only room available on the 600 hall was room [ROOM NUMBER] at the front of the hall. The Administrator was contacted, and she told us to contact the Nurse Consultant. j. On 08/26/2020 at 3:01 p.m., RN #2, was asked to recall the event of 08/20/20 related to (Resident #222's) admission. She reported, He was admitted to 100 hall. He was continually going in and out of his room and into other resident's rooms. Redirection was attempted many times, but he was unable to be redirected. The BOM was the acting Administrator and talked to me about it, she called the Administrator and she said to call the Nurse Consultant. We called her on the phone from my office. She advised us to move him to 600 hall. We had to move another resident out of room [ROOM NUMBER] to make it a private room and put him in the bed B. I put a mask on him, and he immediately started pulling at it. I advised (Nurse Consultant) that we had tried a mask on him, but he wouldn't keep it on. We advised the aides to encourage him and to attempt to keep a mask on him. I notified the 100 hall and the 600 hall nurses to initiate the move and I notified the family. She was asked, What measures were taken to maintain quarantine/isolation while he was on 100 hall? She replied, He was very confused, we tried redirecting him, but that didn't work. That's when we called the Administrator and then the Nurse Consultant. She was asked, Should you have confirmed that isolation precautions were set up after he was moved? She replied, Yes. k. On 08/27/2020 at 04:24 p.m., LPN #4 was asked, Can you tell me about the events of the day of (Resident #222's) admission and his room change? She replied, I was working the lock down unit. When we admit someone, they normally go to the Medicare hall, but he just kept going in and out of his room, so another nurse suggested, I think it was (LPN #2), to put him back on the lock down unit. She was asked, Were isolation precautions established when he arrived on 600 hall? She replied, I didn't see any. She was asked, Did you find it odd that none were set up? She replied, Yes, it was odd. I told them he needed to be in isolation as I was leaving because he was sitting in the dining room and he needed to wear a mask when he out of his room. l. In-services for COVID 19, PPE usage, and Infection Control, including the protocol for 14 day isolation after admission was reviewed and all of the current nursing staff have been in-serviced. m. The New Admission 14 day Isolation policy provided by the Nurse Consultant on 08/28/2020 at 5:40 p.m. documented, .Put resident in standard, contact and droplet isolation following the ADH (Arkansas Department of Health) March 23, 2020 Guide . 2. The Immediate Jeopardy was removed on 08/25/2020 at 5:30 p.m. and the scope and severity reduced to an E when the following plan of removal was implemented: On 8/25/20 at 5:30 p.m., a Plan of Removal was received from the Facility Administrator that documented 1). Resident was admitted on [DATE] and was COVID tested upon admission. Any new admissions will continue to be tested upon admission by the DON/ designee, and placed in 14 day isolation as screening precaution for COVID. 2.) All Residents on the male unit will be screened by the DON/Designee on 8/25/2020 for signs and symptoms of COVID now and Q shift until Covid test results are received. 3.) Starting on 8/25/2020 the DON/designee will in-service all staff as they report to work on proper isolation requirements for new admissions. This will be continued until all direct care staff have ben (been) in-serviced. 4.) The DON/designee will review all new admissions and residents with orders for isolation to ensure that the facility is making every effort to isolate during the 14 day COVID screening period. Daily until substantial compliance is achieved. Any negative findings will be reported to the QA committee for review and recommendations. 5.) Resident will be placed back on 100 hall. Bisquine (Visqueen) will be placed on his door frame with a zipper. A Staff member will be placed outside of door to monitor resident. The patrician on 100 hall that separates the quarantined residents will be zipped closed. 3. On 08/24/2020 at 12:16 PM, an observation was made of Housekeeping Employee #1, on the clean side of the laundry room, without a face covering on the face. Housekeeping Employee #1 was asked, Why do you not have a mask on? She stated, I was told we are able to take them off when we are not around residents.