STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045211	A. BUILDING _____ B. WING _____	09/01/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ARKANSAS NURSING AND REHABILITATION CENTER	2107 DUDLEY STREET TEXARKANA, AR 71854

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 0585 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances.** Complaint # (AR 238) was substantiated, all or in part, with these findings: Based on record review and interview the facility failed to ensure concerns voiced during a Resident Council Meeting were investigated and resolved in a timely manner. This failed practice had the potential to affect all 94 the residents that resided in the facility according to the Census. The findings are: 1. On 8/17/20 at 1:55 PM, the Resident Council Meeting minutes for July (2020) were reviewed. The minutes dated July 7, 2020 documented, . Nursing: residents state that they are having issues with cnas (Certified Nursing Assistants) on the 10/6 (10:00 p.m. - 6:00 a.m.) shift not answering call lights and not making rounds on their hall. Residents state that these cna do not come in their (room) very often during the night and that they are not checking and changing them. The grievance logs dated from 3/11/20 through 8/14/20 were reviewed. There were no grievances relating to these concerns. 2. On 8/20/20 at 2:49 PM, the Administrator was asked if the concerns voiced on July 7, 2020 by the residents had been investigated or addressed. He stated, I think we did an in-service on that. I'll have to check on that. He was asked how complaints were addressed, and he stated, I'm not sure if there was any investigation relating to that (grievance). I think we did an in-service. He stated that he usually got with social and she would make it into a grievance. 3. An in-service titled COVID Infection Control dated 7/13/2020 provided by the Director of Nursing (DON) documented, do not have food or drinks at the nurses stations in the halls or a residents room and please answer call lights in a timely manner.
F 0677 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide care and assistance to perform activities of daily living for any resident who is unable.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Complaint # (AR 385) was substanatiated, all or in part, with a deficiency cited at F677. Based on observation, interview, and record review the facility failed to bathe a resident as evidence by the residents hair becoming matted for 1 (Resident (R) #1) of 5 (Resident #1, #3, #4, #5, and #6) sampled residents who were dependent on staff for bathing. This failed practice had the potential to affect all 97 residents who were dependent on staff for bathing according to the Administrator on 9/14/2020. The findings are: Resident #1 had [DIAGNOSES REDACTED]. The Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 8/07/2020 documented the resident was severely impaired in cognitive skills for daily decision making per a Staff Assessment for Mental Status; and was totally dependent for toilet use, bed mobility, transfers, locomotion on/off unit, dressing, eating, personal hygiene, and bathing. a. The Care Plan with an initiated date of 2/20/2020 documented, .I have impaired cognitive function AND impaired thought processes I HAVE SEVERE COGNITIVE IMPAIRMENT . Communicate with family/caregivers regarding residents capabilities and needs .Discuss concerns about confusion, disease process, NH (nursing home) placement with family/caregivers . Keep my routine consistent and try to provide consistent care givers as much as possible in order to decrease confusion .Monitor/document /report to MD (medical director) any changes in cognitive function, specifically changes in: decision making ability, memory, recall and general awareness, difficulty expressing self, difficulty understanding others, level of consciousness, mental status . MY FAMILY ASSIST with all decision making . I have an ADL Self Care Performance Deficit I REQUIRE ASSIST WITH MY ADL'S . Discuss with resident/family/POA (Power of Attorney) care any concerns related to loss of independence, decline in function . b. On 8/28/2020 at 12:00 PM, Resident #1 was in bed with her eyes opened. Her hair was short. c. On 8/28/2020 at 1:18 PM, Certified Nurses Assistant (CNA) #1 was asked, Did you cut Residents #1's hair? She stated, Yes. CNA #1 was asked, Who told you to cut Resident #1's hair? She stated, I asked the ADON (Assistant Director of Nursing) because it was matted up, nasty, and stinky. I tried to comb it and we couldn't get it loose. CNA #1 was asked, How long was her hair? She stated, The front was like 5 inches, and the back was like 2 inches. The DON (Director of Nursing) said it was Okay. I always cut the residents hair. CNA #1 was asked, Do you know if she asked the family, if it was Okay for Resident #1's hair to be cut? She stated, She (the DON) told me she would ask the family. I think he went back out of town or something. CNA #1 was asked, When you can't comb through a resident's hair do you usually just cut it off? She stated, No. We usually wash it. I ask the family and some of them say yes. d. On 8/31/2020 at 3:29 PM, CNA #2 was asked, What was the condition of Resident #1's hair before it was cut? She stated, It was real long, but it was matted up. CNA #2 was asked, How did it become matted? She stated, They were combing it, but it was so thick. CNA #2 was asked, Do you know if the family gave permission for her hair to be cut? She stated, I don't know if they called the family or not. I'm sure they did for them to cut it. e. On 8/31/2020 at 3:58 PM, the Administrator was asked, Should staff cut a resident's hair without family consent? She stated, Really should have some kind of consent. f. On 9/01/2020 at 9:13 AM, the DON was asked, Did you give staff permission to cut Resident #1's hair? She stated, No. The DON was asked, Were you aware that staff had cut her hair? She stated, Yes. The DON was asked, Did you have a consent for her hair to be cut? She stated, I don't think we need a consent for her hair to be cut. It's a part of grooming, and we cut men hair all the time. g. On 9/01/2020 at 9:40 AM, the DON was asked, Why did Resident #1 hair need to be cut? She stated, The CNA said it was matted from being bed bound, and she moved her head back and forth on the sheet. If staff is combing her hair every day should it be matted? She stated, No.
F 0755 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview the facility failed to ensure nursing staff stayed with a resident until medications were swallowed to prevent potential complications for 1 (Resident #6) of 3 (Residents #3, #5, and #6) sampled residents who received medication from Licensed Practical Nurse (LPN) #1. This failed practice had the potential to affect 15 residents who received medication from LPN#1, as documented on a list provided by the Assistant Director of Nursing (ADON) on 8/23/2020 at 11:55 PM. The findings are: Resident #6 had a [DIAGNOSES REDACTED]. The Admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 6/10/2020 documented the resident scored 15 (13-15 indicates cognitive intact) on a Brief Interview for Mental Status (BIMS) and required supervision with eating. a. The Care Plan dated 6/30/20 documented, .Administer medications as ordered . b. A physician order [REDACTED].[MEDICATION NAME] Capsule Extended Release 500 MG (milligrams) ([MEDICATION NAME] ER) Give 2 capsule by mouth four times a day related to [MEDICAL CONDITION]'S DISEASE OF SMALL INTESTINE WITHOUT COMPLICATIONS . c. On 8/26/2020 at 2:46 PM, Resident #6 was lying in her bed. There was

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 0755 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) a medicine cup with 2 blue pills inside on her bedside table. She was asked, What kind of pills are in the cup? She stated, I didn't know they were there. Resident #6 picked up the cup, then she stated, No. These are for my [MEDICAL CONDITION]'s. e. On 8/26/2020 at 2:51 PM, LPN #1 was asked what kind of pills were in the cup? She stated, [MEDICATION NAME]. She was asked if the medication should be left at the beside table? She stated, She said she would get them. I should watch her take them before I left out. f. On 8/28/2020 at 1:41 PM, the ADON was asked, Should nurses leave medication on the bedside table? She stated, No. She was asked, Can you tell me why? She stated, Because you should watch every patient take their medication. Another patient could take it. They could double up on the medication, or they could miss the medication. g. On 8/31/2020 at 3:58 PM, the Administrator was asked, Should medication be left on the bedside table for a resident to take without the nurse observing? He stated, No. 2. On 8/28/2020 at 1:45 PM, the ADON provided a policy titled Administering Medications. It documented, .Residents may self-administer their own medications only if the Attending Physician, in conjunction with the Interdisciplinary Care Planning Team, has determined that they have the decision-making capacity do so safely .
F 0842 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Complaint # (AR 238) was substantiated, all or in part, with these findings: Based on record review and interview, the facility failed to ensure that documentation of Activities of Daily Living (ADL's) were consistently charted to maintain a complete and accurate record of resident care provided for 2 (Resident #4 and #6) of 6 (Residents 1 - 6) sample residents. This failed practice had the potential to affect all 94 residents that resided in the facility per the Administrator. The findings are: 1. Resident #4 had [DIAGNOSES REDACTED]. The Quarterly Minimum Data Set (MDS) documented rejection of care occurs daily the resident scored 12 (8 - 12 indicates moderately intact) on a Brief Interview for Mental Status (BIMS); and required total care for bed mobility, transfers, dressing, toilet use, and bathing; required limited assistance with locomotion; supervision with eating; extensive assistance with personal hygiene, and was always incontinent, and did not walk; rejection of care occurs daily. a. The records for ADL care did not document any care was provided on August 1-4, 8-10, and 14-16 for 6:00 a.m. - 2 p.m. shift; August 1-4, 9-10 and 15-16 for 2:00 p.m. - 10:00 p.m. shift; and August 1-10, 13-14, and 17 for 10:00 p.m. - 6:00 a.m. shift. b. On 8/20/2020 at 3:27 PM, the Director of Nurses was asked who charted the ADL care for this resident, and she stated, The nurses should have done those. She was looking at the ADL sheet. She was asked what would it indicate to you if there was no documentation, and she stated, It would mean they didn't document, they didn't do it. I don't know why they didn't chart. c. On 8/20/2020 at 4:01 PM, Registered Nurse (RN) #1 was asked if she had taken care of residents on the 300 Hall, and she said that she had on 6:00 p.m. - 6:00 a.m. shift. She was asked if she had performed personal care for them and she stated, We did total care. She was asked where she would document ADL care, and she stated, I don't remember. I would have charted in the Progress notes. As of 8/20/2020 at 12:53 p.m., there was no documentation of ADL care in the Progress Notes. 2. Resident #6 had [DIAGNOSES REDACTED]. Quarterly MDS with an Assessment Reference Date (ARD) 2of 7/14/2020 documented the resident scored a 8 (8-12 indicates moderately impaired) on a BIMS, and required extensive assistance for bed mobility, transfers, personal hygiene, did not walk, limited assistance for locomotion and dressing, supervision for eating and total assistance for bathing; and was always incontinent. The records for ADL care did not document any care was provided on 6:00 a.m. - 2:00 p.m. shift August 1-4, 8-10, and 16th; 2:00 p.m. - 10:00 p.m. shift skips on 1-4th, 8 and 9, and 15th -16th; 10:00 p.m. - 6:00 a.m. shift no documentation 1-10, 13, and 17th.
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 263) was substantiated, all or in part, with these findings: Based on observation, record review, and interviews, the facility failed to ensure isolation precaution signage was placed outside resident room doors staff knew to put on Personal Protective Equipment (PPE) before entering a resident's room who was on isolation to prevent the potential for the spread of infection for 2 (Resident #3 and #5) sample residents who were on isolation. The findings are: 1. On 8/17/2020 at 2:20 PM, a review of the Infection Control logs for July and August (2020) were completed. Resident #3 and #5 were noted to have been on contact isolation for the presence of Extended Spectrum Beta-Lactamase (ESBL) in their urine. The policy and procedure binders were reviewed as well at this time. Under the isolation tab it documented, . 5. When a resident is placed on transmission-based precautions, appropriate notification is placed on the room entrance door and on the front of the chart so that personnel and visitors are aware of the need for and the type of precaution. a. The signage informs the staff of the type of CDC (Centers for Disease Control) precaution(s), instructions for use of PPE, and/or instructions to see a nurse before entering the room. 2. Resident #3 had [DIAGNOSES REDACTED]. The Quarterly Minimum Data Set (MDS) with an Assess2ment Reference Date (ARD) of 7/31/2020 documented the resident scored 11 (8-12 indicates moderately impaired) on a Brief Interview for Mental Status (BIMS); and required extensive assistance for bed mobility, transfers, dressing, toilet use, personal hygiene, and bathing; required supervision with eating, and required [MEDICAL TREATMENT]. a. A Laboratory Requisition sheet documented, . reported 8/9/20. ESBL detected. A hand written order documented, [MEDICATION NAME] 750 mg (milligram) PO (by mouth) q (every) 48 hours x (times) 10 days. Contact Isolation. b. On 8/17/2020 at 12:55 PM, there was an isolation supply cart outside of the door in the hall. There was no signage on the door. Visible in the supply cart were red and yellow isolation bags and on top of the cart was a box of Medium gloves. No one was seen in the room, but there were 2 red tubs with lids in the corner of the room. c. On 8/18/2020 at 9:05 AM, there was a 3 drawer plastic storage bin remained outside of her door. There was no signage was on the door or beside the door. 3. Resident #5 had [DIAGNOSES REDACTED]. The Quarterly MDS with an ARD of 5/17/2020 documented the resident scored 15 (13-15 indicates cognitively intact) on a BIMS; and required limited assistance with bed mobility, transfers, dressing, toilet use, and personal hygiene; required physical help with bathing; and required supervision with eating. a. A physician's orders [REDACTED].Contact isolation precautions d/t (due to) ESBL. [MEDICATION NAME] 750 mg (milligrams) qd (every day). b. On 8/17/2020 at 12:30 PM, there was a plastic supply cart the resident's room. There was no (isolation) signage on the door or visible around it. c. On 8/18/2020 at 9:24 AM, in Resident #5's room, there were 2 red tubs with lids, one contained yellow bag and one contained a red bag. There was no signage on door to indicate the resident was on isolation. d. On 8/18/2020 at 10:33 AM, Housekeeper #2 was asked how she recognized an isolation room, and she stated, If there is a cart outside pointing to the cart outside of R #5's room. She was asked, How do you know what PPE would be required and she stated, We ask the nurse what her illness is. 4. On 8/18/2020 at 9:15 AM, Housekeeper #1 was asked what halls she was cleaning, and she stated, 500 and 600, the shower room, and utility. She was asked if she had any isolation rooms and she stated, No. She was asked how she would know if a room was an isolation room, and she stated, They haven't taught me that yet. She stated shed had been employed about 3 weeks. a. On 8/20/2020 at 2:44 PM, the Housekeeping Supervisor was asked how she trained her staff to recognized isolation rooms. She stated they were trained on donning (putting on) and doffing (taking off) PPE, and I don't turn them loose till (until) I feel they are ready. I stay with them at least 3 days. She was asked how she recognized an isolation room, and she stated, (It) Should be a sign, would be better with a sign, but if it has a container outside the door, I tell them about it and they are to communicate with the nurse. b. On 8/20/2020 at 4:01 PM, the Director of Nurses (DON) was asked how the staff were able to identify an isolation room. She stated, We have isolation set up at the door, and a sign saying what type of isolation they (the resident) are on. She was asked if there were any residents on isolation, and she stated, I don't know.