STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045433	A. BUILDING _____ B. WING _____	06/26/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CORNING THERAPY AND LIVING CENTER	831 NORTH MISSOURI CORNING, AR 72422

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 0625 **Level of harm** - Potential for minimal harm **Residents Affected** - Some	**Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview the facility failed to ensure a resident was provided a bed hold policy prior to discharging from the facility. This failed practice had the potential to affect 1 (Resident #3) of 2 3 (Residents #1, #2, and #3) residents who were discharged from the facility to the hospital according to a list provided by Licensed Practical Nurse (LPN) #1 on 6/25/2020. The findings are: Resident #3 had [DIAGNOSES REDACTED]. The Admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 3/16/2020 documented the resident scored 10 (8-12 moderately impaired) on the Brief Interview for Mental Status (BIMS); required extensive assist x (times) 2 for bed mobility, dressing, and toilet use, and required total assist x 2 for transfers, and required extensive assist x 1 for personal hygiene; and was always incontinent of bowel and bladder. A review of Resident #3 medical record on 5/13/2020 at 11:05 a.m. a did not document a bed hold when discharged to the hospital on [DATE]. An email was sent to the Administrator requesting the bed hold and hospital notification with no return response.
F 0656 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview the facility failed to failed to ensure a Comprehensive Care Plan was developed to address the necessary monitoring and precautions related to the use of an indwelling Foley catheter, to meet the needs of the resident and minimize the potential for complications for 1 of 1 (Resident (R) #1) who had an indwelling Foley catheter. This failed practice had the potential to affect 3 residents who had indwelling Foley catheters according to a list provided by Licensed Practical Nurse (LPN) #1 on 6/26/2020. The findings are: Resident #1 had [DIAGNOSES REDACTED]. The Admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 4/2/2020, documented the resident scored 8 (8-12 moderately impaired) on a Brief Interview for Mental Status (BIMS); required extensive assist x (times) 2 for bed mobility, transfer, dressing, toilet use; and required extensive assist x 1 staff for personal hygiene, had an indwelling Foley catheter and was frequently incontinent of bowel. a Hospital records (ER (emergency room)) dated 4/27/2020, documented, . Catheter-associated UTI .the catheter was exchanged in the emergency department today as it was notably dirty and there was crusting around the urethral meatus and he was noted to have maceration of the skin on the glans penis Acute kidney injury on CKD ([MEDICAL CONDITION]) stage III, likely do to obstruction, patients' catheter on arrival to ED (Emergency Department) was clogged and kinked, appears to not have been changed .A UA (Urine Analysis) was obtained which appears to be consistent with urinary tract infection . b. On 5/1/2020 at 8:50 a.m., a record review of the Admission / Discharge documentation provided by the Administrator, dated 2/1/2020 - 4/30/2020 was conducted. R #1 was admitted to the facility on [DATE]. R#1 was discharged from the facility on 4/5/2020. R#1 was re-admitted to the facility on [DATE]. R#1 was again discharged from the facility on 4/27/2020. c. On 5/5/2020 at 8:00 a.m., the May 1, 2020 physician orders did not document a physician order for [REDACTED].#1 care plan did not contain any documentation for an indwelling Foley catheter or any interventions. e. On 5/6/2020 at 1:26 p.m., a telephone interview was conducted with Registered Nurse (RN) #1. RN #1 was asked, If a resident has a Foley catheter, should that be care planned? RN #1 stated, Yes. f. On 5/6/2020 at 1:58 p.m., the Administrator was asked, If a resident has a Foley catheter, should that be care planned? The Administrator stated, Yes. The Administrator was asked, How do the nurses know what size Foley catheter a resident has, in case an emergency came up? The Administrator stated, It should be in a physician order. The Administrator was asked, How do the nurses / staff know how to take care of a resident's Foley catheter? The Administrator stated, It should be in the Plan of Care (POC). g. On 5/7/2020 at 3:35 p.m., a telephone interview was conducted with LPN #2. LPN#2 was asked, Should there be a physician order if a resident has a a Foley catheter? LPN#2 stated, Yes. LPN #2 was asked, What should that order include? LPN#2 stated, The reason, the size, the date it's ordered, there should be catheter care every shift, input and output. LPN#2 was asked, If a resident has a Foley catheter, should that be care planned? LPN#2 stated, Yes. h. On 5/12/2020 at 7:54 a.m., a record review of a policy titled, Foley Catheter Insertion, Male Resident .The purpose of this procedure is to provide guidelines for the aseptic insertion of a urinary catheter .Verify that there is a physician's order for this procedure .Review the resident's care plan to assess for any special needs of the resident . i. On 5/12/2020 at 7:59 a.m., record review of a policy titled, Catheter Care, Urinary documented, .The purpose of this procedure is to prevent catheter-associated urinary tract infections . Review the resident's care plan to assess for any special need of the resident . j. On 5/12/2020 at 10:03 a.m., a telephone interview was conducted with the Director of Nurses (DON). The DON was asked, Who is responsible for resident's care plans. The DON stated, The MDS Coordinator, LPN #1. The DON was asked, If a resident admits with a Foley catheter or has a Foley catheter, should be care planned with interventions? The DON stated, Yes. The DON was asked, Should a resident have a physician order for [REDACTED]. A policy titled Care Plans - Comprehensive documented, .An individualized comprehensive care plan that includes measurable objectives and timetables to meet the resident's medical, nursing, mental and psychological needs is developed for each resident . The resident's comprehensive care plan is developed within seven (7) days of the completion of the residents' comprehensive assessment .Assessments of residents are ongoing and care plans are revised as information about the resident and the resident's condition change .
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 a resident with an indwelling Foley catheter care plan was updated / revised to maintain and receive care and treatment, and to prevent the potential for infections; and the facility failed to ensure a Care Plan was updated / revised for a resident with wounds to maintain and receive care and treatment and to prevent the potential for infections, in accordance with professional standards of nursing practice. These failed practices had the potential to affect 1 of 1 (Resident (R) #1) with indwelling Foley catheters, and 1 of 1 (Resident #2) with wounds, according to a list provided by Licensed Practical Nurse (LPN) #1 on 6/26/2020. The findings are: 1. Resident #1 had of [MEDICAL CONDITION] (CKD), Urinary Tract Infection [MEDICAL CONDITION], and Type 2 Diabetes Mellitus. The Admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 4/2/2020,

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 0657 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 1) documented the resident scored 8 (8-12 indicates moderately impaired) on a Brief Interview for Mental Status (BIMS); required extensive assist x (times) 2 for bed mobility, transfer, dressing, toilet use, required extensive assist x 1 staff for personal hygiene, and had an indwelling Foley catheter; and was frequently incontinent of bowel. a. On 5/5/2020 at 8:00 a.m., a record review of the physician orders documented there was no physician order for [REDACTED].#1's Care Plan did not contain any documentation for an indwelling Foley catheter or any interventions. c. On 5/6/2020 at 1:26 p.m., a telephone interview was conducted with Registered Nurse (RN) #1. RN #1 was asked, If a resident has a Foley catheter, should that be care planned? RN #1 stated, Yes. RN #1 was asked, If a resident has wounds, should that be care planned? RN #1 stated, Yes. d. On 5/6/2020 at 1:58 p.m., the Administrator was asked, If a resident has a Foley catheter, should that be care planned? The Administrator stated, Yes. The Administrator was asked, How do the nurses know what size Foley catheter a resident has, in case an emergency came up? The Administrator stated, It should be in a physician order. The Administrator was asked, How do the nurses / staff know how to take care of a resident's Foley catheter. The Administrator stated, It should be in the Plan of Care (POC). The Administrator was asked, Should wounds be care planned? The Administrator stated, Yes. e. On 5/7/2020 at 3:35 p.m., a telephone interview was conducted with LPN #2. LPN #2 was asked, Should there be a physician order if a resident has a Foley catheter? LPN #2 stated, Yes. LPN #2 was asked, What should that order include. LPN #2 stated, The reason, the size, the date it's ordered, there should be catheter care every shift, input and output. LPN #2 was asked, If a resident has a Foley catheter, should that be care planned? LPN#2 stated, Yes. LPN #2 was asked, If a resident has wounds, should that be care planned? LPN#2 stated, Yes. f. On 5/12/2020 at 7:54 a.m., a record review of a policy titled, .Foley Catheter Insertion, Male Resident documented, .The purpose of this procedure is to provide guidelines for the aseptic insertion of a urinary catheter .Verify that there is a physician's order for this procedure .Review the resident's care plan to assess for any special needs of the resident . g. On 5/12/2020 at 7:59 a.m., record review of a policy titled, .Catheter Care, Urinary documented, .The purpose of this procedure is to prevent catheter-associated urinary tract infections . Review the resident's care plan to assess for any special need of the resident . h. On 5/12/2020 at 10:03 a.m., a telephone interview was conducted with the Director of Nurses (DON). The DON was asked, Who is responsible for resident's care plans? The DON stated, The MDS Coordinator, LPN #1. The DON was asked, If a resident admits with a Foley catheter or has a Foley catheter, should be care planned with interventions? The DON stated, Yes. The DON was asked, Should a resident have a physician order for [REDACTED]. The DON was asked, If a resident has wounds, should that be care planned? The DON stated, Yes. 2. A policy titled Care Plans - Comprehensive documented, An individualized comprehensive care plan that includes measurable objectives and timetables to meet the resident's medical, nursing, mental and psychological needs is developed for each resident. The resident's comprehensive care plan is developed within seven (7) days of the completion of the residents' comprehensive assessment .Assessments of residents are ongoing and care plans are revised as information about the resident and the resident's condition change . 3. Resident #2 had [DIAGNOSES REDACTED]. The Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 3/18/2020 documented the resident scored 3 on a Staff Assessment for Mental Status (SAMS); required limited assist x 1 for bed mobility, and transfer, required extensive assist x 1 for dressing, toilet use, and personal hygiene; was occasionally incontinent of bladder and always continent of bowel. a. A physician order with a verbal active order date of 4/6/2020 documented, .Clean Stage II to Left buttock with wound cleaner, pat dry and apply nickel thick layer of Normal gel, cover with [MEDICATION NAME] AG, then cover with 12 x 12 Allevyn Adhesive dressing. Change every Mon (Monday)-Wed (Wednesday) and Fri (Friday), Prn (as needed) if soiled until resolved. every day shift every Mon, Wed, Fri . Clean Stage II to Left buttock with wound cleaner, pat dry and apply nickel thick layer of Normal gel, cover with [MEDICATION NAME] AG, then cover with 12 x 12 Allevyn Adhesive dressing. Change every Mon -Wed and Fri, Prn if soiled until resolved. every day shift every Mon, Wed, Fri . b. As of 5/12/2020, the care plan was not revised to reflect R #2 wounds or treatments.
F 0661 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Ensure necessary information is communicated to the resident, and receiving health care provider at the time of a planned discharge.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview the facility failed to ensure discharge summaries were completed after residents discharged from the facility for 2 of 2(Residents (R) #2, #3) discharged from the facility. This failed practice had the potential to affect 6 residents who were discharged according to a list provided by Licensed Practical Nurse #1 on 6/26/2020. The findings are: 1. Resident #2 had a [DIAGNOSES REDACTED]. The Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 3/18/2020 documented the resident scored 3 on the Staff Assessment for Mental Status (SAMS); required limited assist x (times) 1 for bed mobility, and transfer, required extensive assist x 1 for dressing, toilet use, and personal hygiene; and was occasionally incontinent of bladder and always continent of bowel. A Discharge Report dated 4/1/2020 through 4/30/2020 documented R #2 was discharged from the facility on 4/30/2020, there is no documentation of a discharge summary. 2. Resident #3 had [DIAGNOSES REDACTED]. The Admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 3/16/2020 documented the resident scored 10 (8-12 indicates moderately impaired) on a Brief Interview for Mental Status (BIMS); required extensive assist x 2 for bed mobility, dressing, and toilet use, and required total assist x 2 for transfers, and required extensive assist x 1 for personal hygiene; and was always incontinent of bowel and bladder. a. Resident #3 admitted to the facility on [DATE] for managed care. Resident #3 discharged from the facility to the hospital on [DATE]. b. On 5/13/2020 at 11:05 a.m., a record review of the Electronic Health Record (EHR) with no discharge summary documented for the discharge date of [DATE]. 3. On 5/11/2020 at 8:46 a.m., a record review of the facility policy: titled Admissions, Transfer, and Discharge . documented, .The Medical Records office maintains a current Admission, Transfer, and Discharge information . Inquiries concerning admissions, transfers, and/or discharges should be referred to the Medical Records or business office . a. On 5/13/2020 at 11:43 a.m., a telephone interview was conducted with the Business Office Manager (BOM) #1. The BOM #1 was asked, Who is responsible for resident's discharge summaries when a resident discharge from the facility. The BOM #1 stated, I think Nursing, I don't know the proper answer. The BOM #1 was asked, Where are the discharge summaries documented. The BOM #1 stated, Under Assessments in Point Click Care (PCC), under NSG (Nursing) - MD (Doctor) Discharge Summary - V2. The BOM #1 was asked, Can you look at PCC and see if there are discharge summaries for a couple of residents? The BOM #1 stated, I don't have access to the Nursing documents. I have the MDS Coordinator print the forms and I fax them to where they need to go, then I keep it in a file. b. On 5/13/2020 at 11:50 a.m., a telephone interview was conducted with the MDS Coordinator. The MDS Coordinator was asked, Who is responsible for resident's discharge summaries? The MDS Coordinator stated, I am. The MDS Coordinator was asked, Where are the discharge summaries documented? The MDS Coordinator stated, Under resident assessment, NSG-MD Discharge Summary-V2. The MDS Coordinator was asked, Is there a discharge summary for R #2? The MDS Coordinator stated, No ma'am. I'm not seeing one. The MDS Coordinator was asked, Is there a discharge summary for R #3? The MDS Coordinator stated, She does not have one. She discharged to the hospital. The MDS Coordinator was asked, Should there have been a discharge summary for R #3? The MDS Coordinator stated, It was an unplanned discharge. The MDS Coordinator was asked, Did the discharge MDS with an ARD of 3/19/2020, document, .Discharge with no return anticipated? The MDS Coordinator stated, I understand what you're saying. The MDS Coordinator was asked, Should there be a discharge summary? The MDS Coordinator stated, Possibly.
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 the physician was promptly notified of the resident's change in condition / status prior to discharge to prevent further deterioration in health status and to ensure resident received proper treatment. This failed practice had the potential to affect 1 of 1 (Resident (R) #1) case mix resident who had a change of condition according to a list provided by Licensed Practical Nurse (LPN) #2 on 6/26/2020 at 12:40 p.m. The facility failed to ensure a resident with an indwelling Foley catheter had a physician's order to maintain and receive care and treatment, and to prevent the potential for infections, in accordance with professional standards of nursing practice. This failed practice had the potential to affect 1 of 1 (Resident #1) case mix resident with indwelling Foley catheters according to a list provided by Licensed Practical Nurse (LPN) #1 on 6/26/2020. The findings are: 1. Resident #1 had a [DIAGNOSES REDACTED]. The Admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of

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F 0684 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 2) 3/29/2020, documented the resident scored 12 (8 - 12 indicated moderately impaired) on a Brief Interview for Mental Status (BIMS); and required limited assist of 1 staff for all Activity of Daily Living (ADL's), and was always continent of bladder and occasionally incontinent of bowel. a. A physician order dated 3/27/2020 documented, .OT Clarification Order: OT (Occupational Therapy) tx (treatment) 5-7 x (times) week x 4 weeks for ADLs, Transfer Training, There (Therapeutic) act (activity), There exer (exercise) and Safety ED (Education) .Physical Therapy Clarification Order: PT (Physical therapy) 5-7 times per week for 4 weeks with tx of therapeutic exercise, therapeutic activities and gait training . 1). A Care Plan dated 3/26/2020 documented, .The resident has an ADL self-care performance deficit r/t (related to) . PT/OT evaluation and treatment as per MD (doctors) orders .Discharge is uncertain at this time due to (SPECIFY: Resident and responsible party / support person are in disagreement on discharge plan, discharge depends upon significant improvement in status, etc . Evaluate and discuss with the resident/family/caregivers the prognosis for independent or assisted living. Identify, discuss and address limitations, risks, benefits and needs for maximum independence . If the resident is receiving skilled services communicate with (SPECIFY: PT, OT, ST (Speech therapy), nursing) regarding goals that need to be met prior to discharge . 2) On 5/6/2020 at 11:14 a.m., a telephone interview was conducted with Occupational Therapist (OT) #1. OT #1 was asked, How much assistance did R #1 need? OT#1 stated, It varied. He was making some progress, but the last day he had increased bilateral lower extremity pain. Physical Therapy (PT) was addressing that. OT#1 was asked, How far could R #1 walk? OT #1 stated, PTA (Physical therapy assistant) reported he walked over 250 feet with a 4-wheel walker, but it was not our recommendation that he be discharged . OT #1 was asked, Who decided to discharge R #1? OT #1 stated, It was an insurance thing, his insurance ran out. OT #1 was asked, Did R #1 have any problems or complaints with or about his legs? OT#1 stated, Yes. He had made progress, but on the 9th, he had a setback, and on the 10th I saw him. He wasn't walking the time I saw him. OT #1 was asked, If a resident has orders for OT and PT for 4 weeks, why wouldn't the physician order be followed? OT #1 stated, It was our opinion at that point not to discharge, to continue therapy. OT #1 was asked, Would a couple of more weeks of therapy helped the resident to meet his goals? OT #1 stated, Yes. Given the last day he had an increase in leg pain, we could have addressed it. He could have been helped. 3) On 5/6/2020 at 11:52 a.m., a telephone interview was conducted with Activity Director / Social (AD) #1. The AD #1 was asked, Did you fill out the ICP Discharge Summary on R #1? The AD #1 stated, Yes. The AD #1 was asked, Did you notify the resident of the discharge in writing and in a manner, they understood at least 30 days in advance of the discharge? The AD #1 stated, I got the fax (non-coverage Medicare form), on 4/8/2020, notified him of the date the insurance would stop paying. He was able to make his own decisions. The AD #1 was asked, Were you aware R #1 was having bilateral lower extremity issues? The AD #1 stated, I was not aware. 4) A Care Plan dated 3/31/2020, documented, .The resident lacks capacity to understand and make decisions regarding healthcare due to: (Specify) and record does not indicate an Advance Directives / Advance Care Plan (living will) / Healthcare Agent / Healthcare Surrogate / Durable Power of Attorney or other identified healthcare decision maker . 5) A Nursing Every Shift Skilled Charting progress dated 4/8/2020 at 8:00 p.m. documented, Resident very unsteady on feet balance unsteady as well as gait, uses walker to go to b/r (bathroom), otherwise uses w/c (wheelchair) unable to propel chair on own, hands or swollen and painful at times . 6) A PT Therapist Progress & (and) Discharge Summary electronically signed and dated 4/24/2020 documented, .the start of care was 3/27/2020 and the end of care was 4/10/2020, documented: Impact on Burden of Care / Daily Life: SBA (stand by assistance) with most mobility tasks, CGA to min A at times due to Left Knee Pain. Bed Mobility - Supine <> Sit: Goal Not Met. Gait Tasks: Distance-Surfaces: Goal Not Met. Standing Balance: Tinetti Score: Goal Not Met . 7) On 5/7/2020 at 9:34 a.m., a telephone interview was conducted with R #1. R #1 was asked, Did you want to discharge from the facility? R #1 stated, No ma'am. They sent me home. I could hardly walk. R #1 was asked, Do you think you were ready to discharge to home? R #1 stated, No ma'am. They said that was all Medicare would pay for. R #1 was asked, Did it take 3 nurses to get you in the vehicle the day you discharged to home? R #1 stated, Yes ma'am. It took 3 nurses to get me in the car. R #1 was asked, Could you walk the day you discharged to home? R #1 stated, I could walk but not very far, I had to have help. I could take 2-3 steps, but I had to have someone beside me all the time. R #1 was asked, Were your legs swollen and hurting the day you went home? R #1 stated, Yes ma'am. They are still hurting. R #1 was asked, Did you tell anyone about the condition of your legs? R #1 stated, I talked to the nurses, but I don't remember their names. R #1 was asked, Did you tell anyone you didn't want to go home? R #1 stated, Yes ma'am. R #1 was asked, Do you remember who you told? R #1 stated, I don't remember. I told them I wasn't ready to go home, but it didn't do any good. 8) On 5/7/2020 at 3:35 p.m., LPN #1 was asked, Are you familiar with R #1 and were you working the day he discharged ? LPN #1 stated, Yes. LPN #1 was asked, Could he walk? LPN #1 stated, I did not see him walk that day. LPN#1 was asked, What was the condition of R #1 legs? LPN #1 stated, I do not know. LPN #1 was asked, Did R #1 complain to you about pain and [MEDICAL CONDITION] in his legs? LPN #1 stated, He didn't ask for any pain med's (medications). LPN #1 was asked, If a resident has a change in condition, should that be reported? LPN #1 stated, Yes. LPN #1 was asked, Who should it be reported to? LPN #1 stated, If an aide, they report to the nurse and the nurse notifies the physician. 9) On 5/8/2020 at 9:23 a.m., a telephone interview was conducted with the Business Office Manager (BOM) #1. BOM #1 was asked, Was R#1 discharged on [DATE] due to the insurance would not pay. BOM #1 stated, Due to the fact insurance wouldn't pay and the fact he wanted to go home, I know the niece wanted him to stay long term. BOM #1 was asked, Did you or anyone from the facility contact the insurance company to request an extension for services and why? BOM #1 stated, No. Because I was not aware of any clinical changes. If there had been a decline, and someone from the clinical team had contacted me with resident's decline, I could have faxed the information and requested they review it. BOM #1 was asked, Were you aware on 4/8/2020, a nurse charted on R #1, that he was very unsteady on feet, balance unsteady as well as gait, hands swollen and painful at times, and unable to propel self in wheelchair? BOM #1 stated, No. BOM #1 was asked, Were you aware therapy advised R #1 had an increase of pain to bilateral lower extremities prior to discharge? BOM #1 stated, No. I don't go out on the floor. BOM #1 was asked, Do you know if residents' condition was reported and who it was reported to? The BOM #1 stated, No. I don't get into the clinical side of it at all. BOM #1 was asked, What does the Resident's Authorization Form signed by R #1's niece mean. BOM #1 stated, She can sign papers and act on his behalf, but as long as he has the capacity and understanding, he can make decisions. BOM #1 was asked, What about the care plan that documented, .resident lacks the capacity to understand and make decisions regarding healthcare .? BOM #1 stated, That's news to me. BOM #1 was asked, Did R #1 ever say to you he wanted to stay long term? BOM #1 stated, Yes. The first day he came here. He also mentioned (the niece) wants me to stay long term. 10) On 5/8/2020 at 1:34 p.m., a telephone interview with Physical Therapist #1. PT #1 was asked, How much assistance did R #1 need. PT #1 stated, In the last couple of days, he was needing more assistance, one of his knees got to bothering him and he couldn't stand up as long. PT #1 was asked, Did you report that to anyone? PT #1 stated, Right at the end of the stay. I'm sure the nurses knew, because they told me about the knee pain. PT #1 was asked, Did R #1 have any problems or complain of any problems with his legs? PT #1 stated, He was doing fine in the beginning, then his knee started bothering him. PT#1 was asked, If a resident has PT or OT orders for 4 weeks of therapy, why would the order not be followed through? PT#1 stated, Well, it's like standing orders. I'll write for it 4 weeks, and if they progress then we will go from there. PT #1 was asked, What does it mean on the discharge summary if it states, Goals not met. PT #1 stated, We didn't make it to the level of the goal. PT #1 was asked, Was it reported that R #1 had increased leg pain and to who? PT #1 stated, I'm pretty sure it was passed along. I'm certain it was handed to the nursing staff. 11) On 5/12/2020 at 10:03 a.m., a telephone interview was conducted with the Director of Nurses (DON). The DON was asked, Were you aware R #1 was having leg pain and [MEDICAL CONDITION] in lower extremity prior to being discharged on [DATE]. The DON stated, No. The DON was asked, Are you aware a nurse documented on 4/8/2020, the R #1 was very unsteady on feet, balance unsteady as well as gait, hands swollen and painful at times and unable to propel self in wheelchair? The DON stated, No. The DON was asked, Was this change addressed by the staff? The DON stated, I honestly don't know. The DON was asked, Was the physician notified of this change? The DON stated, I do not know. The DON was asked, If a resident has a change of condition, who should that be reported to? The DON stated, It should be reported the physician, the DON, and the Administrator. 12) A policy titled Change in a Resident's Condition or Status documented, .Our facility shall promptly notify the resident, his or her Attending Physician, and representative (sponsor) of changes in the resident's medical/mental condition and/or status . b. On 5/5/2020 at 8:00 a.m., a record review of the most recent physician orders documented there was no physician order for [REDACTED].#1. RN #1 was asked, If a resident has a Foley catheter, should that be care planned? RN #1 stated, Yes. RN #1 was asked, If a resident has wounds, should that be care planned? RN #1 stated, Yes. 3) On 5/6/2020 at 1:58 p.m., the Administrator was asked, If a resident has a Foley catheter, should that be care planned? The Administrator stated, Yes. The Administrator was asked, How do the nurses know what size Foley catheter a resident has, in case an emergency came up? The Administrator stated, It should be in a physician order. The Administrator

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045433	A. BUILDING _____ B. WING _____	**06/26/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CORNING THERAPY AND LIVING CENTER	**831 NORTH MISSOURI CORNING, AR 72422**

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 0684 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 3) was asked, How do the nurses / staff know how to take care of a resident's Foley catheter? The Administrator stated, It should be in the Plan of Care (POC). 4) On 5/7/2020 at 3:35 p.m., a telephone interview was conducted with LPN #2. LPN #2 was asked, Should there be a physician order if a resident has a Foley catheter? LPN#2 stated, Yes. LPN #2 was asked, What should that order include? LPN #2 stated, The reason, the size, the date it's ordered, there should be catheter care every shift, input and output. LPN #2 was asked, If a resident has a Foley catheter, should that be care planned? LPN #2 stated, Yes. 5) On 5/12/2020 at 10:03 a.m., a telephone interview was conducted with the DON. The DON was asked, Who is responsible for resident's care plans? The DON stated, The MDS Coordinator, LPN #1. The DON was asked, If a resident admits with a Foley catheter or has a Foley catheter, should be care planned with interventions? The DON stated, Yes. The DON was asked, Should a resident have a physician order for [REDACTED]. 6) On 5/12/2020 at 7:54 a.m., a record review of a policy titled Foley Catheter Insertion, Male Resident documented, .The purpose of this procedure is to provide guidelines for the aseptic insertion of a urinary catheter .Verify that there is a physician's order for this procedure .Review the resident's care plan to assess for any special needs of the resident . 7) On 5/12/2020 at 7:59 a.m., record review of a policy titled Catheter Care, Urinary documented, .The purpose of this procedure is to prevent catheter-associated urinary tract infections . Review the resident's care plan to assess for any special need of the resident .