| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 045242 | A. BUILDING _____ B. WING _____ | 07/23/2020 |

| NAME OF PROVIDER OF SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP |
|---|---|
| BRIGHTON RIDGE | 235 HUNTSVILLE ROAD EUREKA SPRINGS, AR 72632 |

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) |
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| F 0550<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Some | **Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on observation, interview, and record review, the facility failed to ensure dignity and privacy was respected during a meal and personal information regarding behavior with disease process with an identifier of the resident was not easily visible on a poster board in the hall on 500 hall for 2 (Resident #3 and Resident #11) of 4 (Residents # 3, #11, #25, and #231) sampled residents. This failed practice had the potential to affect 7 residents that required assistance with Activities of Daily Living (ADL) skills on the 500 hall. The findings are: 1. Resident #11 had [DIAGNOSES REDACTED]. The Quarterly Minimum Data Set (MDS) with and ARD (Assessment Reference Date) of 04/27/2020 documented the resident was severely impaired in cognitive skills for daily decision per a Staff Assessment of Mental Status, required total assistance of 1 person for eating. a. On 06/29/2020 at 12:41 P.M., Certified Nursing Assistant (CNA) #1 obtained a meal tray for Resident #11 and entered the resident's room. She set up the lunch meal and began using a spoon to feed the resident mashed potatoes and gravy without speaking with the resident. b. On 06/29/2020 at 12:48 P.M., Resident #11 was lying in her bed with the head of bed elevated being fed pureed foods by CNA #1. CNA #1 did not interact verbally with the resident. CNA #1 continued to assist Resident #11 with her meal for over 5 to 10 minutes without speaking to her. c. On 06/29/2020 at 12:53 P.M., Resident #11 stared straight ahead and would open her mouth when the spoon with food was brought to her mouth and touched her lips. CNA #1 was asked if the resident ever spoke and interacted with her and she said, No, not to me. Resident #11 was asked what her name was. Resident #11 responded appropriately with her first name and smiled. Resident #11 smiled and stated, good to talk with you, before surveyor exited the room. d. On 06/29/2020 at 12:55 P.M., CNA #1 was asked how high the head of Resident #11's bed should be when the resident is eating. She stated, She is probably not up high enough, I probably didn't raise her up high enough. She then raised the head of the bed without notifying or speaking to the resident. The resident startled, jumped in the bed and yelled, Oh, oh! Without speaking to the resident, CNA #1 lowered the head of bed back to approximately 35 degrees which startled the resident who yelled, Oh, no! e. 06/30/2020 at 2:07 P.M., the Director of Nursing (DON) was asked what her expectations were when assisting a resident with eating and staff not speaking or interacting with the resident when offering food and startling the resident by raising and lowering the head of the bed without warning or notifying the resident. She stated, I expect the staff should interact and visit with the resident anytime care is given and assistance with meals are offered. Any staff should tell the resident before they do anything that might startle them or begin care. This is not our desired staff practice at this facility. 2. Resident #3 had [DIAGNOSES REDACTED]. The Quarterly MDS with an ARD of 04/03/2020 documented the resident scored of 6 (0 to 7 indicates severely impaired) per a Brief Interview of Mental Status (BIMS) was independent with ambulation and independent with locomotion on and off the unit. a. On 06/29/2020 at 11:32 A.M., Resident #3's first initial and last name were written on the top of a sign posted in the center of the bulletin board of the 500 hallway that contained the following information: . Stage 5: Moderately Severe Cognitive Decline - Early Dementia. Allen Level 3: Manual Actions Duration of stage approximately 1 1/2 years with subcategories for Memory/ (and or) General; Behavior, ADL (Activities of Daily Living), Delusions their perception of reality. .Sexual acting out at this stage that may go along with delusions, Depression; ADL . Does not anticipate safety hazards; Communication; Motor/Mobility; and Comments . b. On 06/29/2020 at 1:30 P.M., the DON was asked what the sign on the poster board with a resident's name on it was for. She stated, I don't know who put that there, it shouldn't be and took the sign down from the wall. She was asked if she understood what the concern was with the sign and she stated, The name of a resident and privacy. 3. The facility policy regarding resident privacy and dignity was requested from the DON on 06/30/2020 and 07/01/2020 on 3 different occasions. As of 07/02/2020 the policy had not been provided. |
| F 0554<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Few | **Allow residents to self-administer drugs if determined clinically appropriate.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on interview, observation and record review the facility failed to ensure a self-assessment for administration of medication was completed for 1 (Resident # 14) of 1 sampled resident who had eye drops at the bedside. The findings are: Resident #14 had [DIAGNOSES REDACTED]. The Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 05/30/2020 documented the resident scored 10 (8 to 12 indicates moderately impaired in cognitive skills) per a Brief Interview of Mental Status (BIMS), required staff physical assistance of 1 with extensive assistance for bed mobility, transfers, dressing, and personal hygiene. a. Physician's orders documented, Artificial Tears Solution 0.4 % (Hypromellose) Instill 2 drop in both eyes every 4 hours as needed for Dry Eyes dated to start 03/01/2020. b. On 06/29/2020 at 10:41 A.M., a bottle [MEDICATION NAME] Extreme Itch Eye Drops was lying in an emesis basin beside hearing aids on the over the bed table in Resident #14's room. c. On 06/29/2020 at 2:30 P.M., the bottle [MEDICATION NAME] Extreme Itch Eye Drops was at the resident's bedside. d. On 07/01/2020 at 9:45 A.M., the DON reported that she was not aware that the resident had the eye drops at her bedside. She stated that there is no order in the chart. She stated no one in the building has a self-administration assessment and it is not on Resident #14's care plan. e. On 07/01/2020 at 10:45 A.M., the MDS Coordinator stated that she was unaware that the patient had eye drops at bed side. She stated that this medication would be considered an over the counter medication and should be kept by the nurses or the resident be assessed for self-administration. f. On 07/01/2020 at 12:09 P.M., two unnamed Certified Nursing Assistants (CNA), the DON, the Treatment Nurse, and the MDS Coordinator stated they were unaware that Resident #14 [MEDICATION NAME] eye drops and that the family must have brought it in. Due to Covid-19 no family has been in the building since early March due to lock down. g. As of 07/01/2020 there was no physician's order in the resident's chart [MEDICATION NAME] Extreme Itch Eye Drops. h. As of 07/01/2020 there was no documentation of a self-administration screening assessment was in the resident's medical records. The DON was unable to locate a self-administration assessment for Resident #14 as of 07/01/2020 by 5:45 PM i. The Medication Self Administration Assessment Policy and Procedure provided by Consultant on 07/01/2020 at 5:30 P.M. documented: Purpose: To assess a resident's cognitive and physical abilities to safely self-administer medications. Procedure: .3. She (the resident) must demonstrate the ability, cognitively, physically and visually, to complete the task .4. .This will be recorded on a care plan and a teaching plan will be developed for the resident. Obtain a physician's order for self-administration . j. On 07/01/2020 the DON (Director of Nursing) stated no residents in the facility have been assessed or are allowed to self-administer medications. |
| F 0641<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Some | **Ensure each resident receives an accurate assessment.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on observation, interview and record review, the facility failed to ensure the Minimum Data Set (MDS) accurately reflected the use of hearing aids for 1 Resident (Resident #14) of 1 sampled resident that required hearing aids. This |

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 0641<br><br>**Level of harm -** Minimal harm or potential for actual harm<br><br>**Residents Affected -** Some | (continued... from page 1)<br>failed practice had the potential to affect 1 resident who had hearing aids based on a list provided by the Director of Nursing (DON) on 07/02/2020 at 7:40 A.M. The findings are: Resident # 14 had a [DIAGNOSES REDACTED]. a. On 06/29/2020 at 10:45 A.M., Resident #14 was resting in her recliner. There two hearing aids in a basin next to the resident. b. On 06/30/2020 at 1:47 P.M., Resident #14's hearing aids were in a basin on the bedside table. c. On 06/30/2020 at 2:15 P.M., the DON stated the resident has had the hearing aids for a while, she does not wear them all the time and can take them out independently. d. On 07/01/2020 at 10:47 A.M., the MDS Coordinator was asked if the hearing aids were documented on the MDS and the Care Plan. She stated, Probably not, I didn't realize that she had hearing aids. e. 07/01/2020 at 03:46 P.M., a review of the MDS dated [DATE] documented moderately hard of hearing and reports no hearing aids. The MDS dated [DATE] documented resident has minimal difficulty in hearing and reports no hearing aids. f. On 07/01/2020 at 3:49 P.M., Certified Nursing Assistant (CNA) #3 stated the resident does have hearing aids and staff has to help her put them in. He states that he knew she had hearing aids and does have difficulty hearing without her hearing aids. He reports that when she has the hearing aids that it does help her and she is able to hear better. |
| F 0656<br><br>**Level of harm -** Minimal harm or potential for actual harm<br><br>**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.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on observation, interview and record review the facility failed to ensure the care plan was accurately updated to include Activities of Daily Living (ADL) except for transfers for 1 (Resident #2) of 24 sampled residents (Residents #1, #2, #3, #4, #6, #8, #10, #11, #12, #14, #15, #16, #17, #20, #21, #23, #25, #26, #27, #29, #31, #32, #231, and #232) and the care plan was patient centered and updated to identify UTI (urinary tract infection) and implement interventions for infections for 1 (Resident #29) of 6 sampled residents (Residents #2, #3, #4, #14, #16, and #29). These failed practices had the potential to affect 24 residents who received ADL's except transfers per the Resident Matrix provided by the Director of Nursing (DON) 06/29/2020 at 10:57 A.M. and 8 residents who had an UTI in the last 90 days based on a list provided by the DON on 07/02/2020 at 9:29 A.M. The findings are: 1. Resident #2 had [DIAGNOSES REDACTED]. The Annual Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 04/02/2020 documented the resident scored 11 (7 to 12 indicates moderately impaired) per a Brief Interview for Mental Status (BIMS) and required extensive assistance of 2 staff for toileting, transfers, personal hygiene and was frequently incontinent of bladder and bowel. a. On 06/30/2020 at 12:39 P.M., Resident #2's care plan did not list resident's ADL needs. The care plan only identified how to transfer the resident. The care plan did not document the care to be provided for bed mobility, ambulation, toileting, dressing and grooming or the amount of assistance needed for eating. b. On 07/01/2020 at 1:45 P.M., Certified Nursing Assistant (CNA) #4 stated she worked all halls in the building. She was asked how she knew how to perform ADL care to the residents. She stated, The nurses give report or on the report sheet. She stated, There is nothing in writing, I have to rely on them to tell me. She stated that on the task or where we chart it tells her how many person assist, they are. She stated that most of the communication is verbal. c. On 07/01/2020 at 4:30 P.M., Nursing Assistant (NA) #3 stated other CNA's inform him on how to take care of a resident. They tell him in report. d. On 07/01/2020 at 5:00 P.M., the DON was asked if the resident's ADL's should be on the care plan. She stated, Yes, it should be on the care plan, but it is also found on the task when the CNA's document care. 2. Resident #29 has a [DIAGNOSES REDACTED]. The Quarterly MDS with an ARD of 06/07/2020 documented the resident scored 6 (0-7 indicates severely impaired) per a BIMS and required extensive assistance of 1 plus persons for assistance with ADL tasks. a. Lab results dated 5/18/20 documented the resident had a UTI . b. The residents current care plan did not indicate that the resident had the UTI. c. On 07/02/2020 at 8:08 A.M., the MDS Coordinator stated, The infection control nurse is responsible for adding UTI's to the care plan. She stated, UTI's, falls and wounds should be added to the care plan. She stated that she generates the initial care plan then the person over the area of change makes the necessary changes to the care plan. d. On 07/02/2020 at 08:20 A.M., the DON stated, The infection control nurse has been working the floor night shift. She would still have time to keep up with the infection control workload while working night shift. When asked if a UTI should be care planned and she stated, Yes it should be care planned. |
| F 0689<br><br>**Level of harm -** Minimal harm or potential for actual harm<br><br>**Residents Affected -** Some | **Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on observation, interview, and record review the facility failed to ensure hazardous chemicals were stored in a secured storage room on the 500 hall. This failed practice had the potential to affect 6 residents who resided on the 500 hall that were able to ambulate or self-propel in their wheelchair according to a list provided by the Director of Nursing on 07/01/2020. The findings are: 1. On 06/29/2020 at 11:45 A.M., CNA #1 took a trash bag from a resident's room to the clean supply storage room on 500 hall. She opened the unsecured door by the handle and placed the bag in a trash can. The clean supply storage room had clean linens on a shelf in one corner and multiple boxes of supplies including a wire storage shelf with multiple spray bottles of cleaning chemicals hanging by their handles approximately 4 and (one half) feet from the floor. The 1/2 to 2/3 (two thirds) full bottles had labels dated 06/29/2020 at 2:55 P.M. by the Director of Nursing (DON) as follows: a. Disinfectant Cleaner DO NOT DRINK, Caution: Harmful if inhaled or absorbed through the skin. Causes moderate eye irritation. Avoid contact with skin, eyes or clothing. Avoid breathing vapor or spray mist. b. Professional Strength Glass Cleaner Professional Strength Glass Cleaner; For industrial use only - Caution: May cause eye irritation. Wash thoroughly after handling. DO NOT DRINK. c. Disinfectant Cleaner Sanitizer Deodorizer with Organic Soil Tolerance . CAUTION: DO NOT Drink. Caution: May cause eye irritation. Avoid contact with eyes, skin and clothing. Wash thoroughly with soap and water after handling and before eating, drinking, chewing gum, or using tobacco. d. Extra Strength Ammoniated Floor Clean For industrial use only - Corrosive, Causes chemical burns. May cause [MEDICAL CONDITION]. Wear impervious gloves and chemical splash goggles. If in eyes or on skin flush with water. SEEK MEDICAL ATTENTION IMMEDIATELY. DO NOT DRINK. e. Peroxide Multi Surface Cleaner and Disinfectant Active Ingredient Hydrogen Peroxide 8.0%. Causes moderate eye irritation. Harmful if inhaled. Avoid contact with eyes or clothing. DO NOT Drink. 2. On 6/29/2020 at 11:50 A.M., CNA #1 was asked if there were ambulatory residents on the 500 hall or residents that could self-propel that might be confused. She stated, Yes. She was asked if the storage room door should be unlocked where residents could enter with hazardous chemicals hanging on the rack in the room. She stated, I see what you mean, that could be bad. I don't have a key. That door has never been locked when I have been here. She attempted to lock the storage room with her available keys and none of the keys would work. 3. On 6/29/2020 at 11:58 A.M., the DON (Director of Nursing) was asked to come to the 500 hall and check the storage room. She was asked about the storage room not locking and shown the bottles of cleanser chemicals in the room and stated, It should not be open like that, I will see if we have a key and let maintenance know immediately. It shouldn't be left open for the resident's safety. 4. 06/30/2020 02:07 P.M., the DON was asked what her expectations were about the storage room on the 500 door being left unsecure and dirty and clean supplies being in the same room. The DON stated, The dirty trash bin should not have been in with the clean linens and supplies. That room should have never been left unlocked. That aide usually doesn't work on this hall. It is usually locked 5. The facility policy for Accident Hazards provided by the Administrator on 07/01/2020 at 5:10 P.M. documented, Purpose: To ensure the resident environment remains as free as possible of accident hazards and the resident receives adequate supervision and assistance to prevent accidents . The facility will strive to prevent accidents by providing an environment that is free from hazards over which the facility has control. The facility will identify resident risk for accidents and /or falls and adequately plan care and implement procedures to prevent accidents to include but not limited to the storage of chemicals, disposal of chemicals, and other physical hazards. |
| F 0690<br><br>**Level of harm -** Minimal harm or potential for actual harm<br><br>**Residents Affected -** Some | **Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on observation, record review and interview the facility failed to ensure staff provided thorough incontinent care using an appropriate technique to ensure the residents personal hygiene and to prevent the potential development of an |

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| F 0690<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Some | (continued... from page 2)<br>urinary tract infection for 2 (Residents #2 and #231) of 12 (Residents #1, #2, #3, #4, #10, #11, #14, #16, #21, #25, #29 and #231) sample mix residents that required assistance with toileting and or incontinent care. This failed practice had the potential to affect 23 residents who require assistance with incontinent care as documented on a list provided by the Director of Nursing (DON) on at 7:40 A.M. on 07/02/2020. The findings are: 1. Resident #231 had [DIAGNOSES REDACTED]. The<br>Admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 06/25/20 documented the resident scored 1 (0 - 7 indicates severely impaired) per a Brief Interview of Mental Status (BIMS) and required extensive physical assistance of 2 staff for bed mobility, transfers, dressing, toileting, and personal hygiene and was frequently incontinent of urine and always incontinent of bowel. a. On 06/29/2020 at 11:19 A.M., Resident #231 was receiving assistance from Certified Nursing Assistant (CNA) #1 for toileting/incontinent care. CNA #1 donned gloves and pulled down the resident's pants, then removed and discarded the soiled/wet brief. CNA #1 wiped the resident's buttock/perineum area multiple times with wipes and cleansed a small amount of soft brown substance. She discarded the soiled wipes, placed a clean brief on the resident and pulled up the resident's slacks wearing the same soiled gloves she had used to cleanse the resident's buttocks and provide incontinent care. CNA #1 did not use hand sanitizer, handwashing, or change her gloves during or after providing incontinent care. b. On 06/30/2020 at 01:28 P.M., CNA #1 was asked, What would you do differently with incontinent care/toileting of (Resident #231)? She acknowledged she should have and usually would change her gloves and wash her hands before she left the Resident's room. She was asked, Should you have used hand sanitizer, hand washing and changed your gloves between incontinent care and assisting the resident to dress and when leaving the resident's room? She agreed she had used soiled gloves and contaminated the residents clothing, wheelchair, and doorknobs. 2. Resident #2 had [DIAGNOSES REDACTED]. Her Annual MDS with an ARD of 04/02/2020 documented the resident scored 11 (08-12 indicates moderately impaired) per a BIMS and required extensive assistance of 2 staff for toileting, transfers, personal hygiene and was frequently incontinent of bladder and bowel. a. On 06/29/2020 at 1:46 P.M., CNA #1 and CNA #2 entered Resident #2's room to assist the resident with toileting. The resident was assisted to stand. CNA #2 donned gloves and pulled down the resident's slacks and removed the resident's brief. A soft brown substance was noted on the resident's lower posterior area. CNA #2 assisted the resident to stand while he cleansed her buttock/rectum area of the visible soft brown stool using his gloved right hand to clean/wipe and the gloved left hand to position her buttocks. He cleansed the buttocks and wiped the resident front to back. He did not change gloves, do handwashing or sanitizing at any time while doing incontinent care. He removed both gloves and used hand sanitizer after completing the incontinent care. b. On 06/30/2020 at 1:46 P.M., CNA #2 was asked what he would do differently in providing incontinent care/toileting for Resident #2. He stated, I forgot to change my gloves and wash after I cleansed her . c. 06/30/2020 02:07 P.M., The DON was asked what her expectations were when providing incontinent care and toileting to a resident, and when to use hand sanitizer or hand washing . She stated, She should have changed her gloves going from dirty to clean and sanitized her hands or washed them. She should never have assisted dressing or putting on a new brief without hand sanitizer or handwashing. They should have not left the room with hand sanitizing and removing gloves . They should wash or sanitize their hands and change their gloves after dirty and then going to a clean area such as putting on a new brief or clothing . d. On 07/02/2020 at 8:40 A.M., the Policy and Procedure for Incontinent Care provided by the DON documented: PROCEDURE: .10. Change your gloves as needed and wash your hands between glove changes . 20. Remove your gloves and wash your hands before straightening clean linens or providing any other care for the resident . |
| F 0693<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Few | **Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on observation, interview and record review, the facility failed to ensure an enteral feeding tube was flushed with water prior to administering an enteral feeding and the enteral feeding was allowed to flow into the stomach via gravity for 1 (Resident 27) of 1sampled resident who had enteral feeding tubes. The findings are: Resident #27 had [DIAGNOSES REDACTED]. The Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 06/06/2020 documented the resident scored 14 (13 - 15 indicates cognitively intact) per a Brief Interview for Mental Status (BIMS) and required limited assistance of 1 person for eating. a. A physician order [REDACTED].= 474 ml (milliliters)) Bolus via peg (percutaneous endoscopic gastrostomy) every 6 hours four times a day for weight loss . Phone Active 06/29/2020 . b. On 06/30/2020 at 09:18 A.M., Licensed Practical Nurse (LPN) #1 administered an enteral (tube) feeding to Resident #27. The LPN used a 60cc (cubic centimeters) Syringe, without the plunger, connected it to the port and added [MEDICATION NAME] 1.2 cal. and administered per gravity approximately 6.5 ounces. The remainder of the 9.5 ounces was given in 2 ounce increments using the plunger at rate of approximately 2 ounces in approximately 3 minutes. After administration was completed, the tube was flushed with 60cc of water. The cap was replaced on the tube and the syringe was cleaned with water and placed in a syringe bag dated 6/30. c. On 06/30/2020 at 3:45 P.M., LPN #1 was asked if there was anything she should have done after checking placement before starting the bolus feeding. She replied, I should have flushed with water. She was asked if there was an order that allows you to use the plunger. She replied, No. d. The Policy and Procedure for Enteral Nutritional Therapy provided by the DON on 06/30/2020at 3:30 P.M. documented .6. Holding the barrel of the syringe at or below the level of the stomach, pour prescribed amount of water into the syringe. 7. Administer the amount of feeding to be given by holding the syringe 12 to 14 inches above the level of the stomach. Allow the feeding to flow into the stomach very slowly . e. On 07/01/2020 at 4:50 P.M., the DON was asked if a feeding tube should be flushed prior to administering a feeding. She replied, Yes, if there's an order for [REDACTED]. |
| F 0740<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Some | **Ensure each resident must receive and the facility must provide necessary behavioral health care and services.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on observation, interviews and record review, the facility failed to ensure the physician was notified of increased signs and symptoms of depression for 1 (Resident #29) of 13 (#1, #4, #8, #10, #11, #12, #16, #17, #21, #23, #25, #26, and #29) sampled residents who had a [DIAGNOSES REDACTED].M. The findings are: Resident #29 had a [DIAGNOSES REDACTED]. The<br>Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 06/07/2020 documented the resident scored 6 (0 - 7 indicates severely impaired) per a Brief Interview of Mental Status (BIMS), the resident scored 15 on the Resident Mood Interview, and required extensive assistance of 1plus persons for assistance with Activities of Daily Living (ADL) tasks. Had little interest or pleasure in doing things. Feeling down, depressed, or hopeless. a. The Care Plan revised on 03/23/2020 documented, Has mood problems R/T (related to) depression, goal no s/sx (signs and or symptoms) of depression, anxiety or sadness ., Interventions monitor/document/report to MD (Medical Director) refusing to eat, sense of hopelessness, episodes sadness, loss of pleasure and interest in doing things . b. The admission orders [REDACTED]. c. On 06/29/2020 at 10:30 A.M., Resident #29 was asleep in bed. d. On 06/29/2020 at 1:45 P.M., Resident #29 was asleep in bed. e. On 06/30/2020 at 2:20 P.M., Resident #29 was asleep in bed. f. On 07/01/2020 at 7:35 A.M., Resident #29 was sitting in the dining room asleep at the table. g. On 07/01/2020 at 12:45 P.M., Resident #29 was in the dining room and was not eating her meal. Certified Nursing Assistant (CNA) #2 was encouraging her to eat. CNA #2 stated the resident was depressed and sleeping more lately. Also reported the resident was not eating good and losing weight. h. On 07/01/2020 at 8:26 A.M., Resident #29's daughter was contacted by phone. She stated she has not seen her mother since admission to the nursing home due to it being on lock down and her mother has had increased depression since being admitted in the nursing home. She stated she has been told by staff that the resident sleeps a lot and is losing weight. She stated, I know that she is getting more depressed. i. On 07/01/2020 at 10:47 A.M., the MDS Coordinator stated the resident started getting pretty depressed when family couldn't visit. She stated she was admitted on (Antidepressant Medication) and had flagged for depression. The MDS Coordinator was asked, What interventions were put in place to reduce or prevent depression? She stated, Increased calls and window visits with family. She was asked to provide documentation of the interventions and she stated, I probably won't find it. We have had 2 different activities people lately. She was asked what she is supposed to do when a resident is flagged for depression on the Patient Health Questionnaire -9 (PHQ-9). She stated, I would tell the DON at a care plan meeting and I would notify the doctor, but I have not done that. j. On 07/01/2020 at 5:30 P.M., the DON states that she was not notified of the PHQ-9 score increasing from 0 on admission to 15 on the quarterly MDS assessment. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 045242 | A. BUILDING _____ B. WING _____ | 07/23/2020 |

| NAME OF PROVIDER OF SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP |
|---|---|
| BRIGHTON RIDGE | 235 HUNTSVILLE ROAD EUREKA SPRINGS, AR 72632 |

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 0740<br><br>**Level of harm -** Minimal harm or potential for actual harm<br><br>**Residents Affected -** Some | (continued... from page 3)<br>She stated if she had been notified, she would have notified the doctor and attempted other inventions appropriate for the resident. k. As of 7/1/2020, there was no documentation in the nurses notes or medical record the doctor was notified of the resident's increase in behaviors of depression. l. As of 7/1/2020, the DON was unable to provide any documentation of notification to the physician of the resident's increased signs and symptoms of depression. |
| F 0880<br><br>**Level of harm -** Minimal harm or potential for actual harm<br><br>**Residents Affected -** Some | **Provide and implement an infection prevention and control program.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on observation, record review and interview, the facility failed to ensure staff changed gloves and sanitized hands during and after providing incontinent care to prevent the potential spread of infection for 2 (Resident #2 and #231) of 12 sampled residents (Residents #1, #2, #3, #4, #10, #11, #14 #16, #21, #25, #29 and #231) who required assistance with toileting/incontinent care and failed to ensure staff changed gloves, sanitized/(and / or) or washed their hands after removing a residents mask during the lunch meal service on 06/29/2020. These failed practices had the potential to affect 23 residents who required assistance with incontinent care as documented on a list provided by the Director of Nursing (DON) on at 7:40 A.M. on 07/02/2020 and 7 residents who received their meals on the 500 hall as documented on a list provided by the DON on 07/02/2020 at 8:00 A.M. The findings are: 1. Resident #231 had [DIAGNOSES REDACTED]. The Admission<br>Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 06/25/2020 documented the resident scored 1 (0 - 7 indicates severely impaired) per a Brief Interview of Mental Status (BIMS) and required extensive physical assistance of 2 staff for bed mobility, transfers, dressing, toileting, and personal hygiene and was frequently incontinent of urine and always incontinent of bowel. a. On 06/29/2020 at 11:19 A.M., CNA (Certified Nursing Assistant) #1 was assisting Resident #231 with toileting/incontinent care in the resident's bathroom. CNA #1 donned gloves and pulled down resident's pants, removed the soiled/wet brief and assisted the resident to sit down on the toilet in the bathroom. CNA #1 wiped the resident's buttock/perineum area multiple times with wipes and cleansed a small amount of soft brown substance. She discarded the soiled wipes but did not change her gloves, sanitize or wash her hands. She placed a clean brief on the resident assisted her to stand and pulled up her slacks. She then assisted the resident to sit in the chair wearing the same soiled gloves she had used to provide incontinent care. She did not use hand sanitizer, wash her hands or change her gloves at any time during or after she completed the incontinent care and repositioned the resident to a chair. b. On 06/29/2020 at 11:28 A.M., CNA #1 removed the trash bag from the trash can, opened the door and exited the room. CNA #1 did not sanitize her hands, remove or change her soiled gloves before leaving the room or touching the doorknob. CNA #1 carried the trash bag to the storage room on the 500 hall, she grasped the door handle with the soiled gloves and opened the door. She removed the lid from a trash bin and placed the bag in the can and closed the lid. She exited the storage area and removed her gloves, she did not sanitize / or wash her hands. She used the same pair of gloves to provide incontinent care, obtain and apply a clean brief to the resident, assist the resident to dress, open doors to resident's room and the storage room and open the trash bin and close the lid. A hand sanitizer dispenser was by the exit door of the storage room, CNA #1 did not attempt to use. She exited the storage room touching the doorknob and removed her gloves, without washing or sanitizing her hands after removing the gloves and went to the kitchen to obtain her lunch tray. c. On 06/30/2020 at 1:28 P.M., CNA #1 was asked, What would you do differently with incontinent care / toileting of (Resident #231) than you did yesterday when providing care? She acknowledged she should have and usually would change her gloves and wash her hands before she left the Resident's room. She was asked, Should you have used hand sanitizer or hand washing and changed gloves between incontinent care and assisting the resident to dress, getting into the wheelchair, when leaving the room, touching the door knob, and using the door knob to enter the storage area? She agreed she had used soiled gloves and contaminated the residents clothing, wheelchair, doorknobs, and hallway doorknob entry and exit of storage room and removing the lid on the black trash bin beside the clean linens and storage of clean supplies. She made no attempt to use hand sanitizer or hand washing. 2. Resident #2 had [DIAGNOSES REDACTED]. Her Annual MDS with an ARD of 04/02/2020 documented a BIMS score of 11 (7 to 12 indicates moderately impaired) and required extensive assistance of 2 staff for toileting, transfers, personal hygiene and was frequently incontinent of bladder and bowel. a. On 06/29/2020 at 1:46 P.M., CNA #1 and CNA #2 assisted Resident #2 with toileting. CNA #2 donned gloves and pulled down the resident's slacks and removed the resident's brief. CNA #2 gathered 5 cleansing wipes and set the package of extra wipes on the cloth recliner. After the resident used the bedside commode and stated she was finished, CNA #2 assisted her to stand while he cleansed her buttock/anal area of visible soft brown stool using the gloved right hand to clean/wipe and the gloved left hand to position her buttocks. With same soiled right hand glove CNA #2 reached in the open container of wipes for more wipes and cleansed the resident's buttock/anal area. CNA #2 then picked up the package of wipes in his left hand touching the bottom and side of the package of wipes with the same contaminated gloves and placed the package of wipes back in the reclining chair. He did not change his gloves, sanitize or wash his hands at any time while performing incontinent care. CNA #2 placed a new brief on the resident pulled the residents pants up and moved the wipes to the cabinet beside the bed and used the sit to stand lift to place the resident in the recliner wearing the same contaminated gloves. He then removed both gloves after completing the incontinent care and used hand sanitizer. CNA #1 took Resident #2's bedside commode container to the resident's bathroom with her gloves on. She emptied to feces and urine in the toilet and returned the container to the bedside commode without washing or cleansing the container. The bedside commode was set to the side in the resident's room. b. On 06/30/2020 at 1:46 P.M., CNA #2 was asked what he would do differently in providing incontinent care/toileting for Resident #2. He stated, I forgot to change my gloves and wash after I cleansed her and before I put on the new brief. CNA #2 was asked if he should have touched the wipes and the wipe container and returned the container to the fabric chair with soiled gloves. He replied, No. That might contaminate the wipes and the room/furniture. I didn't think. c. On 06/30/2020 at 1:52 P.M., CNA #1 was asked what she usually does when she empties a bedside commode and stated, I should have cleaned it and rinsed it out. I realized it afterwards. d. On 06/30/2020 at 2:07 P.M., the DON was asked what her expectations were when providing incontinent care and toileting to a resident regarding when to use hand sanitizer or hand washing. She stated, She should have changed her gloves going from dirty to clean and sanitized her hands or washed them. She should never have assisted dressing or putting on a new brief without hand sanitizer or handwashing. They should have not left the room without hand sanitizing and removing gloves or entered the storage room with soiled gloves and contaminated the resident room, door or the storage room. The dirty trash bin on 500 should not have been in with the clean linens and supplies and she should have sanitized after removing gloves before leaving the rooms or the hallway. They should wash or sanitize their hands and change their gloves after dirty and then going to a clean area such as putting on a new brief or clothing. The Bedside commode bucket should have been cleansed thoroughly before returning to the bedside commode. e. On 07/02/2020 at 8:40 A.M., the Policy and Procedure for Incontinent Care provided by the DON documented: PROCEDURE: .10. Change your gloves as needed and wash your hands between glove changes. . 20. Remove your gloves and wash your hands before straightening clean linens or providing any other care for the resident . 3. On 06/29/2020 at 12:18 P.M., during the lunch meal on the 500 Hall dining room [ROOM NUMBER] residents where sitting at separate tables. CNA #1 removed the plastic from the cornbread, placed the cornbread in her gloved hands and onto a resident's plate then returned to get another resident's meal tray. Another resident still had her face mask in place and loudly said, I can't get it in my mouth, I can't do this. CNA #1 removed the resident's mask by touching the masks outer surface with her gloved hands and laid the mask beside the resident. Without sanitizing or washing her hands or changing her gloves CNA #1 then proceeded to obtain and set up the next 3 resident's meal trays. She removed the lids, opened the plastic wrapped around the cornbread and placed it on the residents' meal tray. She unrolled the silverware from the cloth napkin and laid the silverware on the resident tray touching the spoon surface. CNA #1 moved Resident #3's chair to assist the resident to get up. Without sanitizing or washing her hands or changing gloves CNA #1 continued to set up other resident's meal trays in the dining room. CNA #1 then obtained a meal tray off the cart for Resident #11 and entered the resident's room and assisted her with the meal without sanitizing her hands or changing her gloves. |