STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045359	A. BUILDING _____ B. WING _____	09/04/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
THE WATERS OF CUMBERLAND, LLC	1516 CUMBERLAND ST LITTLE ROCK, AR 72202

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 0558 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Reasonably accommodate the needs and preferences of each resident.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, and interview the facility failed to ensure an overbed table was provided for 1 (Residents #1) of 22 Residents (Residents #68, #44, #40, #41, #25, #71, #5, #8, 65, #22, #18, #55, #62, #46, #35, #49, #56, #36, #1, #38, #31, #17, and #28) sampled residents who were provided overbed tables. This failed practice had the potential to affect 61 residents who were identified as eating on an overbed table according to a list provided by the Director of Nursing (DON) on 9/4/2020 at 8:01 a.m. The findings are: Resident (R) #1 had [DIAGNOSES REDACTED]. The Admission Minimum Data Set with as assessment reference date of 8/18/2020 documented the resident scored 11 (8-12 indicates moderately impaired) on a Brief Interview for Mental Status and she was independent with eating with no assistance required from staff. a. The Care Plan revised on 8/14/20 documented, (Resident #1) has potential nutritional problem . requires mechanically altered diet secondary to mental condition Encourage the resident to comply. Explain consequences of refusal, obesity/malnutrition risk factors. Monitor/document/report PRN any s/sx of dysphagia: Pocketing, Choking, Coughing, Drooling, holding food in mouth, several attempts at swallowing, Refusing to eat . b. On 08/31/20 at 12:35 p.m., the resident was eating lunch on her bed and there was no overbed table. c. On 09/01/20 at 8:05 a.m., the resident was eating breakfast from a tray on her bed. She was asked, Is this how you prefer to eat your meals? She stated, It's all I have. She was asked, Would you like an overbed table? She stated, Yes. When asked, Have you asked for one? She stated, Yes, they said they didn't have one. d. On 9/1/2020 at 8:07 a.m., Certified Nursing Assistant (CNA) #3 was asked, Is it normal for R#1 to eat off her bed? She stated, That's how she likes it. She was asked, Is it normal for someone to eat off their bed? She stated, No usually they have an overbed table. She was asked, Has she been offered an overbed table? She stated, Not that I'm aware of. She was asked, Should she have an overbed table to eat off of? She stated, Yes. e. On 09/01/20 at 10:01 a.m., the resident was outside smoking. She was asked, Did they bring you an overbed table? She stated, Yes.
F 0623 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to notify the residents and the resident's representative (s) of the transfer or discharge and the reason for the move in writing for 3 (Residents #40, 38 and 71) of 3 sampled residents who were transferred to the hospital in the last 4 months. The failed practice had the potential to affect 16 residents who were transferred in the last 4 months according to a list provided by the Director of Nursing (DON) on 09/04/2020. The findings are: 1. Resident #40 had [DIAGNOSES REDACTED]. The Quarterly MDS dated [DATE] documented the resident scored 14 on a Brief Interview of Mental Status (BIMS) and required extensive assistance of one person with bed mobility, transfers and activities of daily living (ADLs). a. A Nurses Note dated 08/21/2020 at 21:52 documented, .Note Text: Lab notified facility of critical K+ (Potassium) 6.5 APRN (Advanced Practice Registered Nurse) spoke with resident regarding critical level of potassium. Resident agreed to go to hospital for treatment and/or evaluation. DON and sister notified and aware. MEMS (Medical Emergency Management Service) notified for transport . Resident transported onto stretcher and exit out facility alert and oriented . b. A Nurses Note dated 8/25/2020 at 22:50 documented, .Note Text: Resident re-admit back to facility. From Hospital with Dx (Diagnosis): [MEDICAL CONDITION]. Potassium WNL (within normal limits) (4.9) . Received discharge orders . c. On 09/02/2020 at 10:10 AM, the DON informed this surveyor that she was unable to locate the transfer notifications. She stated, I can just tell you now I don't have them (transfer notifications). The Social Director left, and she was responsible for doing them, I've looked in her office and I can't find them. The DON was asked, Should the facility provide written notification to the residents and the resident's representative (s) of the transfer or discharge and the reason for the move in writing? She stated, Yes. 2. Resident #38 was admitted to Hospice on 06/05/20 with [DIAGNOSES REDACTED]. On 09/01/20 at 10:25 AM record review of the progress notes in the electronic record documented the resident was hosptalized on [DATE]-05/6/20, and 05/20/20-05/28/20. b. On 09/02/20 at 09:00 AM the Director of Nursing (DON) was asked, Do you have the transfer notification that was mailed to the resident's representative regarding his transfer to the hospital? At 10:00 AM, the DON was asked, Do you have a hospital transfer notification for Resident #38's hospitalization ? She stated, There are no transfer letters or bed hold letters that I can find . 3. Resident #71 was admitted to Hospice on 07/23/20 with [DIAGNOSES REDACTED]. a. On 09/01/20 at 02:55 PM, record reviewed of the progress notes in the electronic record documented the resident was admitted to the hospital on [DATE]-07/01/20. b. On 09/02/20 at 09:00 AM the Director of Nursing (DON) was asked, Do you have the transfer notification that was mailed to the resident's representative regarding his transfer to the hospital? At 10:00 AM, the DON was asked, Do you have a hospital transfer notification for Resident #71's hospitalization ? She stated, There are no transfer letters or bed hold letters that I can find .
F 0625 **Level of harm** - Minimal harm or potential for actual 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 record review and interview, the facility failed to ensure a bed hold policy notification was provided to the resident, and resident representative for 3 (Resident #71, #38, and #75) of 3 sampled residents that required a bed hold policy. This failed practice had the potential to affect 14 residents who was transferred to a hospital and required a bed hold policy as documented on a list provided by the Administrator 09/04/20 at 08:01 AM: The findings are: 1. Resident #71 was admitted to Hospice on 07/23/20 with [DIAGNOSES REDACTED]. a. On 09/01/20 at 02:55 PM, record reviewed of the progress notes in the electronic record documented the resident was admitted to the hospital on [DATE]-07/01/20. b. On 09/02/20 at 09:00 AM the Director of Nursing (DON) was asked, Do you have the transfer notification that was mailed to the resident's representative regarding his transfer to the hospital? At 10:00 AM, the DON was asked, Do you have a hospital transfer notification for Resident #71's hospitalization ? She stated, There are no transfer letters or bed hold letters that I can find . 2. Resident #38 was admitted to Hospice on 06/05/20 with [DIAGNOSES REDACTED]. On 09/01/20 at 10:25 AM record review of the progress notes in the electronic record documented the resident was hosptalized on [DATE]-05/6/20, and 05/20/20-05/28/20. b. On 09/02/20 at 09:00 AM the Director of Nursing (DON) was asked, Do you have the transfer notification that was mailed to the resident's representative regarding his transfer to the hospital? At 10:00 AM, the DON was asked, Do you have a hospital transfer notification for Resident #38's hospitalization ? She stated, There are no transfer letters or bed hold letters that I can find . 3. Resident #75 had [DIAGNOSES REDACTED]. The Discharge Return Not

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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F 0625 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 1) Anticipated with an assessment reference date of 6/30/2020 documented admitted from acute care hospital on [DATE] and discharged to acute care hospital on [DATE]. On 9/03/20 at 9:49 AM., the DON was asked, Was there a discharge letter sent to the family, resident and ombudsman that he was sent out? The DON stated, I know what happened, but it's not documented anywhere. There is no letter completed 4. The Bed Hold Policy received from the Administrator on 09/04/20 at 09:45 AM., documented, It is the policy of the facility to provide the Resident, Resident's family member and/or the Resident's legal representative, if applicable, in written form and/or by a telephone conversation prior to transfer to a hospital or prior to a resident beginning therapeutic leave, for a duration of 24 hours or longer; certain information regarding the Resident's facility bed status and how the bed will be held.
F 0637 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Assess the resident when there is a significant change in condition** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interview, the facility failed to ensure a comprehensive assessment was completed within 14 days after determining that a major change in the resident's status had occurred for 2 (Residents #71 and #38) of 3 (Residents #40, #71 and #38) sampled residents who required a comprehensive assessment completed within 14 days. This failed practice had the potential to affect 5 residents who required a comprehensive assessment as documented on a list provided by the Minimum Data Set Coordinator (MDS) on 09/04/20 at 09:10 AM. The findings are: 1. Resident #71 was admitted to Hospice on 07/23/20 with [DIAGNOSES REDACTED]. Resident required extensive to total assistance of one person for activities of daily living. a. The Significant change MDS with an ARD of 08/06/20 was signed by the Registered Nurse (RN) on 08/19/20. The Significant change MDS was not completed within the 14 days of determining the status change was significant. b. On 09/03/20 at 10:00 AM, the Director of Nursing (DON) was asked, Do you know why the Significant MDS was not signed within the 14-day period? She stated, No, I don't know because I don't sign them, the MDS person will complete the assessment and send it to the person over her to sign it I'm not sure who she is. c. On 09/03/20 at 10:24 AM, the MDS Coordinator was asked, Do you know why the Significant change MDS was not signed within 14 days of the significant change? She stated, No I'm not sure, because when I complete them, my MDS Consultant Registered Nurse reviews them and she is the one that signs them, she then stated, I think she checks the MDS every other day. 2. Resident #38 was admitted to the Hospice on 06/05/20 with [DIAGNOSES REDACTED]. a. The Physician order [REDACTED]. The Significant Change MDS with an ARD of 06/26/20 was not completed and dated by the RN until 07/08/20. b. On 09/02/20 at 02:00 PM, the Care Plan updated 07/20/20 documented, Resident #38 has chosen to receive Hospice Services r/t (related to) [MEDICAL CONDITION].
F 0640 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Encode each resident's assessment data and transmit these data to the State within 7 days of assessment.** Based on record review and interview, the facility failed to ensure Minimum Data Set (MDS) were transmitted within 14 days after completion to ensure resident-specific information was available for quality measures purposes for 2 (Residents #3, and #2) of 25 (Residents #3, #2, #68, #44, #40, #41, #25, #71, #5, #8, 65, #22, #18, #55, #62, #46, #35, #49, #56, #36, #1, #38, #31, #17 and #28) sampled residents that MDS were reviewed. This failed practice only impacted Resident #3 and Resident #2. The findings are: 1. On 9/01/20 at 4:44 PM Resident #3 Death in Facility MDS with an ARD of 4/27/2020 was completed but never submitted 2. Resident #2 Quarterly MDS with an ARD of 5/24/2020 was exported to a file but the file was not submitted. 3. On 09/02/20 at 03:20 PM, the MDS Coordinator was asked, Were Resident #3 Death in Facility and Resident #2 Quarterly assessments submitted? She stated, No it doesn't look like it. When asked, Why not? She stated, I don't submit the MDS, the Consultant RN submits them. She was asked, Will you inform her? She stated, Yes ma'am I will.
F 0641 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Ensure each resident receives an accurate assessment.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure the Minimum Data Set (MDS) assessment accurately reflected medication use based upon pharmaceutical category for 1 (Resident #70) of 2 (Residents #70 and #8) case mix residents who are currently ordered [MEDICATION NAME]. This failed practice had the potential to affect 3 residents who were ordered [MEDICATION NAME] according to a list provided by the MDS Coordinator on 9/4/20 at 9:11 AM. The findings are: 1. Resident #70 had [DIAGNOSES REDACTED]. The Annual MDS with an Assessment Reference Date (ARD) of 8/9/20 documented the resident scored 13 (13-15 indicates cognitively intact) on a Brief Interview for Mental Status (BIMS) and received anticoagulant 7 of the past 7 days. a. A physician's orders [REDACTED]. b. The care plan revised on 7/1/20 did not address the use of an anticoagulant. c. On 09/04/20 at 09:57 AM, the MDS Coordinator was asked how medications are coded in Section N of the MDS. She stated, What do you mean. It was then explained to her that according to the Resident Assessment Instrument (RAI) drugs are to be coded according to class, not their use. The MDS Coordinator was then asked if the MDS was correct. She replied, No. I'll modify.
F 0645 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**PASARR screening for Mental disorders or Intellectual Disabilities** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interview, the facility failed to ensure a Preadmission Screening and Resident Review (PASRR) was completed, to determine the eligibility for the level of care provided in a nursing facility any specialized services for 1 (Resident #68) of 6 (Residents #25, #8, #49, #36, #1, and #38) sampled residents who required a PASRR. This failed practice had the potential to affect 20 residents who required a PASRR as documented on a list provided by the Director of Nursing (DON) on 09/04/20 at 08:01 AM. The findings are: Resident #68 had [DIAGNOSES REDACTED]. a. On 09/01/20 at 11:36 AM, record reviewed and there was no PASRR found in the resident's current documents. b. On 09/02/20 at 10:12 AM, the DON was asked, Do you have a PASRR assessment for resident (Resident #68?)?She stated, I can't find anything in her medical record, and she has been here for a long time. I called (Professional Associates), they told me they could not find any records of an assessment that they had performed on this resident. c. On 09/02/20 at 12:51 PM, The Business Office Manager (BOM) was asked, Do you have any information for a PASRR assessment for Resident #68 from the (Professional Associates)? She stated, (Resident #68) has been here for a while, but she should have one, I will look through her records and see if I can find anything. d. On 09/04/20 at 08:36 AM, the DON stated, We do not have a policy for PASRR, we just follow Federal Regulations.
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 record review and interview, the facility failed to accurately document the interventions for Nothing by mouth (NPO) status to minimize the potential for choking hazards for 1 (Resident #22) of 1 resident who was NPO. This failed practice had the potential to affect 1 resident as documented on the NPO list provided by the Dietary Service Manager on 9/3/2020 at 1:39 p.m. The facility also failed to ensure the use of an electric scooter was documented for 1 (Resident #36) of 1 resident to promote continuity of care. The findings are: 1. Resident #22 had [DIAGNOSES REDACTED]. The Admission MDS with an ARD of 6/15/2020 documented the resident was severely impaired in cognitive skills for daily decision making per a staff assessment for mental status required extensive assistance of one person for eating, tube feeding portion of calories 51% or more, average fluid as 500cc (cubic centimeter) or more and a mechanical lift. a. A Physician order [REDACTED]. b. The Care Plan dated 6/18/20 documented, The resident has dehydration or potential fluid deficit . Offer drinks during one-to-one visits. Ensure that all beverages offered comply with diet/fluid restrictions and consistency requirements. Has DM (Diabetes Mellitus) Offer substitutes for foods not eaten . The resident requires tube feeding Percutaneous Endoscopic gastrostomy (PEG) r/t (related to) Dysphagia, Swallowing problem .[MEDICATION NAME] 1.5 (at) 50cc/hr (hour) . The resident needs assistance with tube feeding and water flushes. See MD (Medical Doctor) orders for current feeding orders. Check for tube placement and gastric contents/residual volume per facility protocol and record . c. On 8/31/20 at 12:30 p.m., the resident received PEG TF (total feed) running at 55 cc hour with 150 ml (milliliter) flush of water every 4 hours. 2. Resident #65 had [DIAGNOSES REDACTED]. The Admission MDS with an ARD of 8/12/2020 documented the resident scored 15 (13-15 indicates cognitively intact) on a BIMS transfers as independent with no staff assistance, wheelchair (manual or electric) as yes. a. The Care Plan documented, I am currently independent with all my ADLs (activity of daily living) I am able to take myself to specific areas usually such as my room, dining room, activities, etc. (etcetera), but if needed, please cue

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F 0656 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 2) me . There was no documentation in the Care Plan of a use for a wheelchair or a scooter. b. On 08/31/2020 at 10:44 AM the resident was mobile in the facility via an electric scooter. c. As of 8/31/2020 at 11:05 PM there was no scooter assessment completed in the resident's record. d. On 9/3/2020 at 9:48 AM the resident was in his scooter, going out to smoke. e. On 9/3/2020 at 9:50 AM, the DON was asked, Is there an assessment for scooter use? She stated, Let me look and see, no there is not. She was asked, How do you ensure a resident is safe to operate a scooter? She stated, We can't. She was asked, Should it be documented on the care plan? She stated Yes. At 10:00 AM, the MDS Coordinator was asked, Is the scooter care planned for (Resident #65)? She stated, No. When asked, Should it be? She stated, Yes. f. On 9/3/2020 at 10:06 AM, the MDS Coordinator was asked, What is the care plan for? She stated, To tell them how care is provided.
F 0657 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure the person-centered Care Plan was updated to identify the resident's successful removal of his Personal Safety Device for 1 (Resident #55) of 1 sampled resident, who was identified as an elopement risk. This failed practice had the potential to affect 2 residents who wore Personal Safety Devices according to a list provided by the Director of Nursing (DON) on 09/03/2020 at 9:49 AM. The findings are: Resident (R) #55 had [DIAGNOSES REDACTED]. The Admission MDS with an assessment reference date of 07/22/2020 documented the resident scored 3 (0-7 indicates severely impaired) on a Brief Interview for Mental Status and required extensive assistance of one person with bed mobility, transfers and activities of daily living (ADLs). a. The Comprehensive Care Plan dated 07/16/2020 documented, . (Resident #55) is an elopement risk/wanderer . Wander Alert . There was no documentation in the Care Plan related to the resident occasionally removing his Wander Alert. b. The July, August and September 2020 Medication Administration Records (MARs) documented, .Check Placement of Wander Guard .once a shift .three times a day for Elopement . c. The August 2020 and September 2020 Physician order [REDACTED]. d. On 08/31/20 at 02:19 PM during initial rounds, R #55 wandered about the secure unit without any assistive devices. He wandered in and out of the day room, in the hallway, and attempted to enter other resident's rooms. A Certified Nursing Assistant (CNA) was 1:1 with the resident providing redirection. Resident #55 was easily redirected. e. On 09/01/2020 at 12:34 PM, R #55 was in the day room at a table being assisted by CNA # with his lunch. When he finished his lunch the CNA #5 was asked if the resident was wearing a Wander Alert and she stated, Yes. She was asked, Which leg is it on? She began to check both of the resident's legs and stated, I know he's had one on before because I've seen it on him. He takes it off sometimes, we may find it in the bed, in the floor, anywhere. She was asked, He can take it off? She stated, Yes 'ma'am, I don't know how he does it, but he can get it off. She was asked, What should you do if he is takes it off or you find it somewhere? She stated, Tell the nurse. f. On 09/01/2020 at 02:57 PM, R #55 was in the day room sitting at a table and was still not wearing a Wander Alert. He followed directions to expose his ankles and wrists when asked. When asked, where was his ankle bracelet. He just stared. g. On 09/02/20 at 08:27 AM, Resident #55 was sitting at a table eating. CNA #10 was asked which leg the Wander Alert was on. She checked and Resident #55 had a Wander Alert on his right ankle. The CNA was asked when the Alert was put on the resident and why he wasn't wearing it yesterday. CNA #10 stated, They put it on him last night. He takes it off. She was asked, What should you do if he takes it off? She stated, Let the nurse know. h. On 09/02/20 at 08:36 AM, Licensed Practical Nurse (LPN) #5 was asked, Should R #55 have the Wander Alert on at all times? She stated, Yes. He takes it off all the time. We find it everywhere . She was asked, Should this be care planned? She said, It should be, I think it is. I will check. She was asked, When should the Wander Alert be replaced? She stated, As soon as possible. She was asked, How do you monitor care provision by staff? She stated, I go behind them and I'm in the hall all the times giving medications and doing something with the residents. I check on them. She was asked, Were you informed that R #55 removed his Wander Alert yesterday and it wasn't put back on till night shift? She stated, Yes, they finally told me. She was asked, Whose responsibility is it to put it back on? She stated, Anybody can put it back on. i. On 09/02/20 at 03:08 PM, the DON was asked, Should residents with Personal Safety Devices have them on at all times? She stated, Yes. I know that R #55 will take his off. She was asked, What should staff do if the resident removes the device? She stated, They should report it to the nurse. She was asked, When should the device be replaced? She stated, Immediately. She was asked, If the resident is known to remove the device frequently is this a safety issue and should it be care planned? She stated, Yes. She was asked, How do you monitor care provided by staff? She stated, I'm always out making rounds on the units and I talk to them and the residents. j. On 09/02/2020 at 03:27 PM, a Policy and Procedure for Personal Safety Devices for Resident at Risk for Elopement provided by the DON documented, .It is the policy of this facility that all resident are provided adequate supervision .All residents assessed to be at risk of elopement will be provided with a Personal Safety Device . k. On 09/02/2020 at 03:27 PM, a Policy and Procedure for Personal Safety Devices for Resident at Risk for Elopement provided by the DON documented, . (2). The primary care physician for all residents identified of being a risk of elopement will be notified and an order will be obtained for a Personal Safety Device . (3). The order for the Personal Safety Device will be written on the Physician order [REDACTED]. (7). Personal Safety Devices will be replaced immediately if they have been determined to not function properly .
F 0661 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**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 record review and interview, the facility failed to ensure a written discharge summary was completed that included a recapitulation of the resident's stay that consisted of a concise summary of the stay, course of treatment, a reconciliation of medications, and discharge plans to provide necessary medical information and recommended follow-up care for the continuing care provider for 1 (Resident #73) of 2 (Residents #73 and 75) residents who were discharged in the past 90 days. This failed practice had the potential to affect 6 residents according to a list provided by the Director of Nursing (DON) on 9/4/20 at 8:01 a.m. The findings are: Resident #73 had a [DIAGNOSES REDACTED]. The Admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) 3/25/20 documented the resident scored 14 (13-15 indicates cognitively intact) on a Brief Interview for Mental Status. A Discharge Return Not Anticipated MDS with an ARD of 6/4/20 documented the resident was discharged to another nursing facility. a. The Discharge Summary dated 6/4/20 documented Resident left facility @ (at) 1700 (5:00 p.m.) in w/c (wheelchair) via facility van to (Nursing home). All belongings were packed by dayshift CNA and transferred to van by Housekeeper supervisor and staff coordinator. Narcotic signed out by DON and other medications left with resident as well. Resident A&Ox4 (alert and oriented times 4) upon departure and resident stated, I'm excited to return back to home. No c/o (complaints of) pain/discomfort voiced at this time. b. A physician's orders [REDACTED]. c. On 09/03/20 at 8:49 a.m., the closed record and electronic health record contained no documentation on the Discharge Summary or a recapitulation of the resident's stay. The DON was asked, why the resident was discharged and if there was any other information regarding the discharge. She stated, What you see in there is probably all we got. There was an agreement with (Nursing Home) for us to take 17 of their patients because of COVID. So, we can see their records and stuff like the Minimum Data Set (MDS), and they can see ours too in (electronic health record). Her and the family wanted her to go back to (Nursing Home) so that's why she was discharged back.
F 0677 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**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** Based on observation, record review, and interview, the facility failed to ensure residents' facial hair was regularly removed to maintain good grooming for 1 (Resident #31) of 10 (Residents #44, #56, #22, #46, #31, #71, #62, #17, #40 and #55) sampled residents who were dependent on staff for removal of facial hair. This failed practice had the potential to affect 32 residents who were dependent on staff for facial hair removal, according to the list provided by the Administrator on 09/04/20 at 08:55 AM. The facility also failed to ensure residents fingernails and toenails were cleaned and trimmed to promote good personal hygiene and grooming for 5 (Residents # 17, #31, #41, #62 and 71) of 47 (Residents

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F 0677 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 3) #68, 44, 48, 45, 40, 50, 11, 4, 41, 25, 42, 71, 63, 3, 14, 75, 8, 72, 65, 22, 18, 55, 37, 58, 62, 46, 57, 35, 49, 73, 51, 70, 56, 30, 36, 43, 1, 24, 38, 31, 17, 60, 2, 66, 28, 13 and 20) residents who required assistance with nail care. This failed practice had the potential to affect 70 residents according to the Resident Census and Condition of Resident Form. The findings are: 1. Resident (R) #31 had a [DIAGNOSES REDACTED]. a. A Plan of Care dated 07/20/20 documented, Routine Care needs and Activities of Daily Living. Please check my fingernail and toenail length and trim as needed unless I am a diabetic. The Care Plan did not contain any interventions related to the removal of facial hair. b. On 08/31/20 at 11:09 AM, Resident #31 was sitting in his wheelchair at the bedside. Resident's facial hair was unkempt around his chin, mouth and upper lip that was approximately inch in length. (Photo taken). He was asked, Does it bother you when your facial hair is grown out? He stated, Yes it does, I haven't had a shave in over a week, and I have told the nurses I wanted a shave, but I haven't got one yet. Before the pandemic my son would come in and shave me and trim my nails. I shaved every other day when I was at home, but I do keep my mustache. He was asked, Do you know who you asked for a shave? He stated, No, I don't know her name, but it was one of the nurses. He also stated, They don't clean and file my nails. Fingernails were dirty with jagged edges approximately inch in length (Photo taken). c. On 09/01/20 at 09:00 AM, the resident was sitting in his wheelchair in the room. He stated, I did get my bath and they finally shaved me yesterday evening. They still didn't trim or clean my nails. The nails on both hands are still dirty with dark substance under the nails with jagged edges. d. On 09/01/20 at 11:16 AM, Licensed Practical Nurse (LPN) #1 was asked, Who's responsible for shaving residents? She stated, The residents are usually shaved on shower days and whenever they need one if they don't refuse care. She was asked, Who is responsible for trimming and cleaning nails? She stated, I can trim their nails, we all can clean them, they are supposed to be cleaned and filed on shower days, the nurses have to trim the diabetic nails. e. On 09/02/20 at 11:29 AM, the DON was asked, Who is responsible for shaving residents? She stated, Residents should be shaved on shower or bath days. She was asked, Who is responsible for trimming and cleaning residents' fingernails? She stated, Any of the CNAs or the nurses can clean the resident's nails and they should be cleaning them when they bathe or shower them and whenever they need it. The nurses have to trim the resident's nails if they are a diabetic. 2. Resident #71 had [DIAGNOSES REDACTED]. A Significant Change Minimum (MDS) with an ARD of 08/06/20 documented the resident scored 4 (0-7 indicates severely impaired) on a BIMS, required extensive to total assistance of one person for ADL care. a. The Care Plan dated 08/28/20 documented, (Resident #71) has an Activities Daily Living (ADL) self-care performance deficit .requires moderate to maximum assistance with ADL's d/t (due to) contracture to UE (upper extremity) and LE's (lower extremities) and left hand secondary to history of [MEDICAL CONDITION](Cardiovascular Accident). b. On 08/31/20 at 03:08 PM, the resident was lying in bed with eyes open. The resident's fingernails were untrimmed and jagged, with a dark substance underneath them. (Photo taken). c. On 09/01/20 at 11:16 AM, Licensed Practical Nurse (LPN) #1 was asked, Who is responsible for trimming and cleaning nails? She stated, Any nurse can trim their nails if they are a diabetic, we all can clean them, they are supposed to be cleaned and filed on shower days, the nurses have to trim the diabetic nails. The activity director trims their fingernails sometimes. She was asked, Do you think (R#71's) nails need to be trimmed? She stated, Yes they do. d. On 09/01/20 at 11:47 AM, Certified Nursing Assistant (CNA) #2 was asked, Who is responsible for trimming and cleaning nails? She stated, The activity director trims nails sometimes, we can trim them if they are not a diabetic, and any of us can clean residents' nails, we usually clean them on shower days. 3. Resident #17 had [DIAGNOSES REDACTED]. The Quarterly MDS with an ARD of 06/20/2020 documented the resident scored 7 (0-7 indicates severely impaired) on a BIMS, required extensive assist of one person with bed mobility, transfers, toileting and personal hygiene. a. The Comprehensive Care Plan with a revision date of 06/15/2020 documented, Please check my fingernail and toenail length and trim as needed unless I am diabetic. Please notify my nurse if I need my toenails trimmed . b. On 08/31/20 at 01:21 PM, R #17 was lying quietly in bed. The resident had a right wrist contracture, and the fingernails on both his right and left hands had a dark colored substance underneath them and they had grown about a quarter of an inch past the tips of his fingers. The resident was asked if he would like to have his nails cleaned and trimmed and he stated, Yes. He was asked, Has anyone offered to provide nail care recently? He stated, No. CNA # 8 entered the room from the hallway and was asked to assist surveyor in observing resident's fingernails. She was asked, Who is responsible for providing nail care? She stated, We all are. The nurses if they're diabetic and we do the rest. She was asked, When is nail care provided? She stated, Every bath day and whenever they need it. She was asked, Can you explain why this resident's nails have dirt underneath and need trimming? She stated, I'm not sure. c. On 08/31/20 at 01:29 PM, Licensed Practical Nurse (LPN) #5 was asked, Who is responsible for nail care? She stated, CNAs and Nurses if they are diabetic. She was asked, When is nail care provided? She stated, Every day if they need it, but every bath or shower day. She was asked, Can you explain why R #17's nails have dirt underneath and need trimming? She stated, I don't know. I will find the aide. She was asked, Is the resident cooperative with baths and nail care? She stated, Yes he is very cooperative and very nice. She was asked, How do you monitor care provided by staff? She stated, I am out here on the hall all the time and I go behind them. d. On 09/02/2020 at 12:04 PM, a Nail Care Policy provided by the DON documented, .It is the policy of the facility to provide personal hygiene needs and to promote health, safety and the prevention of infection. This includes clean, smooth nails at a well-groomed safe length acceptable to the resident . 4. Resident #62 had [DIAGNOSES REDACTED]. The Annual MDS dated [DATE] documented the resident scored 13 (13-15 indicates cognitively intact) on a BIMS and required extensive assistance of one person with bed mobility, transfers and activities of daily living. a. The Plan of Care dated 8/28/2020 documented, .The resident has an ADL self-care performance deficit . b. On 08/31/20 at 01:40 PM, the resident stated his nails needed trimming. When asked does the staff offer to clean and trim his nails he said, No. He stated, They just say, 'We'll get to it'. The nails on both of his hands were long, more than 1/4 inch beyond the tips of his fingers and had a dark substance underneath. c. On 09/03/20 at 09:48 AM, Resident #62 fingernails were still in need of trimming and cleaning. The Treatment Nurse was standing outside door and said she would go find the CNA. d. On 09/03/20 at 09:52 AM, CNA #5 was asked, Who is responsible for nail care? She stated, CNAs and if they're Diabetic, the nurses do it. She was asked, How often and she stated, Every shower day or whenever they need it, like after they eat. 5. Resident #41 had [DIAGNOSES REDACTED]. The Quarterly MDS with an ARD of 7/6/20 documented the resident was totally dependent on the assistant of one person for personal hygiene. a. The Care Plan completed on 8/5/20 documented, . (Resident #41) requires assistance with ADLs r/t weakness; dementia, [MEDICAL CONDITION] . Keep resident's nails clean and cut . b. On 08/31/20 at 12:23 PM, the resident was resting in a geriatric chair with untrimmed nails and a thick layer of a light brown substance underneath the thumbnail to the left hand. (Surveyor took a photo). c. On 09/02/20 at 12:20 PM, CNA #6 was asked when resident receives nail care. She stated, We do him on his bath day, so it'll be done today.
F 0686 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide appropriate pressure ulcer care and prevent new ulcers from developing.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interview the facility failed to ensure turning and repositioned was done for 1 (Resident #56) of 1 resident who required turning/repositioning. The failed practice had the potential to affect 7 residents dependent on staff for turning as identified on the list provided by the Director of Nursing (DON) on 9/4/2020 at 10:08 a.m. The findings are: Resident (R) #56 had [DIAGNOSES REDACTED]. The Quarterly Minimum Data Set with an Assessment Reference Date of 8/1/20 documented the resident scored 14 (13-15 indicates cognitively intact) on a Brief Interview for Mental Status; required extensive one-person assistance for bed mobility and was dependent upon two persons for transfers. a. The Care Plan with a completion date of 6/8/20 documented, .Resident is at risk of skin breakdown/ pressure ulcer r/t (related to) Impaired Mobility, Incontinence . Turn/ re- position Q (every) 2 hours and PRN (as needed) .The resident has an ADL self-care performance deficit r/t Limited Mobility, Limited ROM, (range of motion) Stroke . BED MOBILITY: The resident is totally dependent on (1) staff for repositioning and turning in bed (Q 2 hours) and as necessary . b. On 08/31/20 at 10:39 AM, the resident was lying in supine position on an air mattress bed with the head of bed at approximately 45 degrees. R #56 was asked if he was comfortable, he stated No. R #56 was asked if staff repositioned him recently, he replied No, I haven't been turned today. c. On 09/01/20 at 08:48 AM, the resident was lying in supine position in bed at approximately 45-degree angle. R #56 was asked if he was repositioned any last night, he stated, No, they didn't turn me once. R #56 was asked if he ever hit his call light to be repositioned, he stated No. At 09:47 AM the resident was lying in bed awake watching tv. The resident was in the same supine position on the air mattress. At 11:05 AM, the resident was lying in bed in supine position with feet elevated. R #56 was asked if they provided care for him recently, he stated

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	045359	A. BUILDING _____ B. WING _____	09/04/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
THE WATERS OF CUMBERLAND, LLC	1516 CUMBERLAND ST LITTLE ROCK, AR 72202

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F 0686 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 4) Yeah, they just left. He was asked if staff offered to reposition him, he stated No. d. On 09/02/20 at 02:49 PM, Licensed Practical Nurse (LPN) #4 was asked how often residents should be turned. She stated, Should be every two hours.
F 0688 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to ensure hand rolls were consistently utilized as per the Plan of Care to prevent further decline in range of motion for 1 (Residents #71) of 3 (Resident #68, #71, and #44) sampled residents who had hand contractures. These failed practices had the potential to affect 4 residents who had contractures, according to a list provided by the Administrator on 09/04/20 at 09:56 AM. The findings are: Resident #71 had [DIAGNOSES REDACTED]. a. The Care Plan dated 08/28/20 documented, (Resident #71) has an ADL self-care performance deficit . Requires moderate to maximum assistance with ADL's due to contracture. Left hand roll to left hand as tolerated secondary to contractures on admission . b. On 08/31/20 at 11:32 AM, the resident was lying in bed awake. He had a contracture of the left hand without a splint or device in place. (photo taken) c. On 09/02/20 at 09:40 AM, Certified Nursing Assistant (CNA) #2 was asked, Does this resident have a hand roll? She stated, Yes, he has one, but he won't keep it in his hand. She was asked, Do you know where it is at? She stated, No I don't. d. On 09/02/20 at 10:00 AM, the Director of Nursing was asked, Does Resident #71 use his hand roll? She stated, Yes he has one, but I will tell you now he will not keep it in his hand. She was asked, Should it be care planned if the resident refused care or if he won't keep it in his hand? She stated, Yes it should be.
F 0689 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to ensure a mechanical lift was utilized in accordance with the manufacturer's instructions to minimize the potential for transfer-related injuries for 2 (Residents #41 and #22) of 7 (Residents #56, #41, #22, #35, #68, #71, and #62) case mix residents who required the use of a mechanical lift for transfers. This failed practice had the potential to affect 11 residents who required the use of a mechanical lift for transfers, according to a list provided by the Director of Nursing (DON) on 9/4/20 at 8:01 a.m. Failed to ensure wander alert devices were always in place for 2 (Resident #70 and #55) of 2 sampled resident who had Personal Safety Devices. The failed practice had the potential to affect 2 residents who wore Personal Safety Devices according to a list provided by the DON on 9/3/20. The facility also failed to ensure a smoking apron was applied at smoke time for 1 (Resident #36) of 4 sampled resident who smoked to prevent potential injury. This failed practice had the potential to affect 19 residents who smoked according to a list provided by the DON on 9/4/20. The findings are: 1. Resident #22 had [DIAGNOSES REDACTED]. The Admission MDS with an ARD of 6/15/2020 documented the resident was severely impaired in cognitive skills for daily decision making per a staff assessment for mental status and used a mechanical lift for transfers. a. The Care Plan dated 6/18/20 documented, Require assist x (times) 2 staff and a MECHANICAL LIFT WITH ALL TRANSFERS . b. The Lift Assessment completed 7/4/2020 documented type of lift required, Total Dependent Full body Lift, sling size large 2-person assist. c. On 09/01/20 at 10:10 AM, observed Certified Nursing Assistant (CNA #6) and Licensed Practical Nurse (LPN #1) use the Invacare Drive mechanical lift to lift patient from the bed to the chair. The lift was placed under the bed with the legs not separated. LPN #1 lifted resident up and moved the lift from under the bed to the side of the Geri-chair. The legs were separated slightly upon approaching the Geri-chair he was lowered into the G-chair from the side of the chair with CNA #6 positioning the sling, the locks of the lift were never applied. 2. Resident #41 had [DIAGNOSES REDACTED]. The Quarterly MDS with an ARD of 7/6/20 documented the resident was totally dependent on two plus persons for bed mobility and transfers and had a functional limitation in range of motion of lower extremities with an impairment on both sides. a. The Care Plan completed on 8/5/20 documented, . (Resident #41) requires assistance with ADLs r/t weakness; dementia, [MEDICAL CONDITION] . dependent assist of one in bed mobility, 2 staff and use of Hoyer lift for all transfers . b. On 09/02/20 at 01:22 PM, Certified Nursing Assistant (CNA) #6 and CNA #7 used the mechanical lift to place resident in bed from his geriatric chair. CNA #6 positioned the lift over the resident in the geriatric chair with the legs of the lift closed. CNA #7 then attached the straps of the lift pad to the mechanical lift. CNA #6 then used the lift to raise the resident up and brought him over to the bed and lowered him down, while the legs of the lift were still closed. The CNAs never opened the legs of the lift or locked the brakes during the transfer. At 01:34 PM, CNA #6 and CNA #7 were asked when the last time they were in-serviced on the mechanical lift. CNA #6 stated, It's been so long I don't remember, but they go over it like once a year or something. CNA #6 was then asked if she knew what she did during the transfer that did not correlate with the manufacturer's guidelines. CNA #6 stated, Open the legs. there's really not enough room in there to open the legs without bumping into things. CNA #6 was asked about the locks. She replied, No, we didn't lock it. 3. Resident #70 had [DIAGNOSES REDACTED]. The Admission Minimum Data Set MDS with an assessment reference date of 07/30/2020 documented the resident was independent with transfers and activities of daily (ADLs), wander/elopement alarm: not in use. a. The Plan of Care dated 08/03/2020 documented, The resident is an elopement risk r/t (related to) history of attempts to leave facility unattended . There was no documentation of the Wander Alert in the record. b. On 09/03/20 at 09:57 AM, this surveyor went to secure unit. An unidentified CNA was sitting in the day room with a group of residents. She was asked if anyone on the unit was wearing an ankle bracelet and she said Resident #70. When she asked Resident #70 which ankle his Alert was on, he stated, It's in my pocket. I took it off because it was irritating me. An unidentified CNA checked the resident's ankle and he was not wearing the Wander Alert. He pulled it out of his pocket and gave it to her. She was asked, Should he have the Alert on at all times? She stated, Yes. She was asked, Has he ever removed his bracelet before? She stated, Not that I'm aware of. She was asked, What should you do when he removes it? She stated, I'm going to tell the nurse right now. c. On 09/03/2020 at 11:12 AM, the MDS Coordinator was asked, Should Wander Alerts be documented in the MDS and addressed in the Care Plan? She stated, Yes. Is there a reason Resident #70's current MDS does not show that he has a Wander Alert and it's not mentioned in his care plan? She stated, I didn't know he had one, the nurses didn't tell me and there is no order where I could have seen that he had one . The MDS Coordinator was asked to check her computer for monitoring of placement of the device on a Medication or Treatment Record. She stated, I don't see it. d. On 9/3/20 at 11:20 AM, the DON was asked, Should the MDS include documentation that Resident #70 is wearing a Wander Alert? She stated, Yes. She was asked, Should it be care plan? She stated, I think it should be. 4. Resident (R) #55 had [DIAGNOSES REDACTED]. The Admission MDS with an assessment reference date of 07/22/2020 documented the resident scored 3 (0-7 indicates severely impaired) on a Brief Interview for Mental Status and required extensive assistance of one person with bed mobility, transfers and activities of daily living (ADLs). a. The Comprehensive Care Plan dated 07/16/2020 documented, . (Resident #55) is an elopement risk/wanderer . Wander Alert . There was no documentation in the Care Plan related to the resident occasionally removing his Wander Alert. b. The August 2020 and September 2020 Physician order [REDACTED]. c. On 08/31/20 at 02:19 PM during initial rounds, R #55 wandered about the secure unit without any assistive devices. He wandered in and out of the day room, in the hallway, and attempted to enter other resident's rooms. A Certified Nursing Assistant (CNA) was 1:1 with the resident providing redirection. Resident #55 was easily redirected. d. On 09/01/2020 at 12:34 PM, R #55 was in the day room at a table being assisted by CNA #5 with his lunch. When he finished his lunch CNA #5 was asked if the resident was wearing a Wander Alert and she stated, Yes. She was asked, Which leg is it on? She began to check both of the resident's legs and stated, I know he's had one on before because I've seen it on him. He takes it off sometimes, we may find it in the bed, in the floor, anywhere. She was asked, He can take it off? She stated, Yes 'ma'am, I don't know how he does it, but he can get it off. She was asked, What should you do if he is takes it off or you find it somewhere? She stated, Tell the nurse. e. On 09/01/2020 at 02:57 PM, R #55 was in the day room sitting at a table and was still not wearing a Wander Alert. He followed directions to expose his ankles and wrists when asked. When asked, where was his ankle bracelet. He just stared. f. On 09/02/20 at 08:36 AM, LPN #5 was asked, Should R #55 have the Wander Alert on at all times? She stated, Yes, He takes it off all the time. We find it everywhere . She was asked, How do you monitor care provision by staff? She stated, I go behind them and I'm in the hall all the times giving medications and

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F 0689 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 5) doing something with the residents. I check on them. She was asked, Were you informed that R #55 removed his Wander Alert yesterday and it wasn't put back on till night shift? She stated, Yes, they finally told me. She was asked, Whose responsibility is it to put it back on? She stated, Anybody can put it back on. g. On 09/02/20 at 03:08 PM, the DON was asked, Should residents with Personal Safety Devices have them on at all times? She stated, Yes. She was asked, What should staff do if the resident removes the device? She stated, They should report it to the nurse. She was asked, If the resident is known to remove the device frequently is this a safety issue .? She stated, Yes, I agree. h. On 09/02/2020 at 03:27 PM, a Policy and Procedure for Personal Safety Devices for Resident at Risk for Elopement provided by the DON documented, .It is the policy of this facility that all resident are provided adequate supervision .All residents assessed to be at risk of elopement will be provided with a Personal Safety Device . i. On 09/02/2020 at 03:27 PM, a Policy and Procedure for Personal Safety Devices for Resident at Risk for Elopement provided by the DON documented, . (2). The Primary Care Physician for all residents identified of being at risk of elopement will be notified and an order will be obtained for a Personal Safety Device . (3). The order for the Personal Safety Device will be written on the Physician order [REDACTED]. (7). Personal Safety Devices will be replaced immediately if they have been determined to not function properly . 5. Resident #36 had [DIAGNOSES REDACTED]. The Admission MDS with an ARD of 3/26/2020 documented current tobacco use as yes. The Quarterly MDS with an ARD of 6/26/2020 documented the resident scored 15 (13-15 indicates cognitively intact) on a BIMS. a. The Care Plan dated 5/12/20 documented, I have chosen to continue to smoke and need you to observe me for safety . Will be safe while smoking . I may need to wear a smoker's apron when I smoke due to safety concerns, if I do please make sure and put it on me then help me take it off after I smoke . I need you to supervise me, assure I can safely reach the ashtray, and to assist to make sure my cigarette is fully distinguished each time, so I do not burn myself . b. On 08/31/20 at 02:20 PM, an unidentified CNA placed a smoking apron on the resident. The resident smoked her cigarette, no ashes fell on her and she extinguished the cigarette safely. c. On 09/01/20 at 09:00 AM, the resident was smoking a cigarette and had the smoking apron in place. d. On 9/02/20 at 9:50 a.m., the resident was outside smoking with no apron on. CNA #4 was asked, Should she have an apron on? The CNA stated, Yes, she did yesterday. She was asked, Why isn't she wearing one today? She stated, This is her second cigarette I just came out now, it was another person. CNA #5 provided the smoke break at 9:00 a.m. She was asked, Is Resident #36 supposed to wear a smoking apron? CNA #5 stated, No, I remember the last time they told me it wasn't necessary.
F 0690 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interview, the facility failed to ensure the catheter was properly secured and stabilized to prevent accidental dislodgement and promote maximal comfort for 1 (Resident #17) of 2 (Residents #17 and #20) sampled residents who had an indwelling catheter. The failed practice had the potential to affect 2 residents who had indwelling catheters according to a list provided by the Director of Nursing (DON) on 09/03/2020 at 09:49 AM. The findings are: Resident #17 had [DIAGNOSES REDACTED]. The Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 06/20/2020 documented the resident scored 7 (0-7 indicates severely impaired) on a Brief Interview for Mental Status (BIMS) and required extensive assist of one person with bed mobility, transfers, toileting and personal hygiene. a. On 08/31/20 at 01:30 PM, a foley catheter was hanging on the right side of Resident #17's bed. It was not in a privacy bag. Resident was in a private room and when asked stated it didn't bother him that he didn't have a privacy bag. The CNA present was asked about the no stat-loc in place to secure tubing. She stated she will further investigate missing stat-loc. She was asked, What should you do if no stat loc is present? She stated, Tell the nurse. b. On 09/01/20 at 11:25 AM, Resident #17 was lying in bed and there was no stat loc in place to secure the foley catheter tubing. Licensed Practical Nurse (LPN) #1 was asked to accompany this surveyor to the resident's room. She was asked to check the resident for a stat loc. When she saw no stat loc she was asked, Why isn't foley secured with stat loc? She stated, Nobody told me he didn't have one. She was asked, Who's responsible for applying? She stated, Any nurse. c. A Policy on Foley Stabilization provided by the DON on 9/2/20 documented, .Purpose: Foley Stabilization devices are used to reduce Foley catheter movement, minimize accidental catheter dislodgement, and maximize patient comfort .
F 0693 **Level of harm** - Minimal harm or potential for actual harm **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.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interview, the facility failed to ensure gastrostomy tube (GT) placement was checked as ordered and failed to ensure the physician order [REDACTED].#22) of 1 sampled resident who received medication via a gastrostomy tube. This failed practice had the potential to affect 1 resident who received tube feedings, as documented on the Resident Census and Conditions of Residents form provided dated 8/31/2020. The findings are: Resident #22 had [DIAGNOSES REDACTED]. The Admission MDS with an ARD of 6/15/2020 documented the resident was severely impaired in cognitive skills for daily decision making per a staff assessment for mental status required extensive assistance of one with eating, received tube feeding portion of calories 51% or more, and average fluid intake of 500cc (cubic centimeter) or more. a. A Physician order [REDACTED]. b. The care plan dated 6/18/20 documented, Has dehydration or potential fluid deficit . Requires tube feeding r/t (related to) Dysphagia, Swallowing . [MEDICATION NAME] 1.5 @ (at) 50cc/hr (per hour) .needs assistance with tube feeding and water flushes. Check for tube placement and gastric contents/residual volume per facility protocol and record . c. On 9/01/20 at 10:00 a.m., Licensed Practical Nurse (LPN) #4 disconnected the TF and paused the pump during transfer to Geri- Chair via mechanical lift. LPN #1 used the controls of the lift, pushed the lift into the hall came back in reconnected the TF and set the pump to run. Placement was not verified. LPN #1 was asked, Should placement be verified? She stated, Yes d. On 9/02/20 at 7:11 a.m. LPN #4 was at the 100/200 med cart preparing medication for Resident #22. She had 2 measured cups in which meds were placed. She added water to 160 ml to one cup and 130 ml to the 2nd cup. At 7:23 p.m., she verified [DEVICE] placement with 25ml of air followed by aspiration and pulled back to 45ml. She then administered both med cups into the tube, per gravity. She threw the syringe away and obtained a new one. When asked why? She stated, I can't believe I just did that. e. On 9/02/20 at 2:35 p.m., LPN #4 was asked, Why do you think there is an order to flush the GT with water after administering meds? She stated, Because it might not all get in with the water at the end, I thought maybe I should've flushed with plain water. f. On 9/03/20 at 01:29 PM, The Policy and Procedure for Enteral Tube Care and Feeding documented, .Placement is verified before feedings, flush, or medication administration and PRN. Connect 60 cc syringe to the tube and aspirate. Connect 60 cc syringe to the tube and instill 20cc air while auscultating gastric area with the stethoscope; listen for air insufflation.
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 medications were ordered promptly to ensure availability of all prescribed medication to prevent complications for 1 (Resident #22) of 1 resident who did not receive all their physician ordered medication. The findings are: Resident #22 had [DIAGNOSES REDACTED]. The Admission MDS with an ARD of 6/15/2020 documented the resident was severely impaired in cognitive skills for daily decision making per a staff assessment for mental status, required extensive assistance of one with eating, received tube feeding portion of calories 51% or more, and average fluid intake of 500cc (cubic centimeter) or more. a. On 9/2/20 at 7:11 a.m., Licensed Practical Nurse (LPN) #4 prepared the 100/200 medication cart for medication administration. Resident #22 Medication Administration Record [REDACTED]. The LPN stated, I don't have it in yet, it was ordered yesterday or the day before. b. On 9/2/2020 at 11:35 a.m., the (Pharmacy) medication daily order form dated 9/2/2020 documented LPN #3, the 11:00-7:00 nurse ordered [MEDICATION NAME] 2.5mg. c. On 9/2/2020 at 11:35 a.m., a review of the Policy and Procedure documented, .reorder medication three to four days in advance of need to assure an adequate supply is on hand.
F 0761 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Ensure drugs and biologicals used in the facility are labeled in accordance with**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045359	A. BUILDING _____ B. WING _____	09/04/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
THE WATERS OF CUMBERLAND, LLC	1516 CUMBERLAND ST LITTLE ROCK, AR 72202

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 0761 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 6) **currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the facility failed to ensure expired over-the-counter drugs stored in 2 (Cart ,[DATE] and [DATE]) of 3 (,[DATE], ,[DATE] and [DATE]) medication carts were disposed of in accordance with the manufacturer's expiration date to prevent potential administration of medications. This failed practice had the potential to affect 1 resident who had physician's orders [REDACTED]. On [DATE] at 7:04 a.m., the Medication Cart for 100 / 200 Hall was inspected with the assistance of Licensed Practical Nurse (LPN) #4. The Medication Cart contained one bottle of Zinc Sulfate 220 mg (milligrams) with an expiration date of February 2020. LPN #4 removed the bottle of zinc from the cart and stated, No one takes this anyway. 2. On [DATE] at 7:57 a.m., the Medication Cart for [DATE] hall was inspected with the assistance of LPN #5. The Medication Cart contained two bottles of Folic Acid 400 mg with an expiration date of February 2020. LPN#5 removed both medications from the cart and stated, They're not even open yet.
F 0812 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the facility failed to ensure freezer temperature was maintained at a level to keep frozen food solid to prevent potential bacteria growth; expired food items were promptly removed/ discarded by the expiration or use by dates to prevent potential for food bone illness; and ice machines and ice scoop holder were maintained in clean and sanitary condition to prevent contamination of airborne particles in 1 of 1 facility. These failed practices had the potential to affect 69 residents who received meals from the kitchen (total census:70), as documented on a list provided by Food Service Supervisor (FSS) on [DATE] at 1:39 pm and the findings are: 1. On [DATE] at 10:05 am, the temperature of the ice cream freezer in the storage room was 27 degrees Fahrenheit. Thirty-nine cartons of magic cups in a box on a shelf in the freezer were soft to touch. At 10:37 AM, Dietary Employee #1 was asked how many cartons of magic cups were in the box. He counts the cartons of magic cups and stated, There were 39 cups and there were soft to touch. At 11:39 am, the Maintenance Supervisor informed surveyors that he would have someone to come and look at the freezer. 2. On [DATE] at 10:10 a.m., the following observations were made on a rack in the storage room: a. There were two boxes of 46 fluid ounces of cranberry cocktail juice on the shelf with an expiration date of [DATE]. b. An opened box of baking soda was in an open zip lock bag on a rack in the storage room. c. An open bag of hamburger bun was on a bread rack in the storage room with an expiration date of [DATE]. 3. On [DATE] at 10:57 AM, there were black residue on the panel of the ice machine in a room on 100 Hall. Dietary Employee #1 was asked how often you clean the ice machine and who used the ice from the machine. He stated, We clean it every week. The CNAs (Certified Nursing Assistants) use it for the water pitchers in the residents' rooms and to fill beverages served to the residents at mealtimes. Dietary Employee #1 was asked to describe the appearance of the black wet residue on the panel of the ice machine that could fall on ice. He stated, Black residue. 4. On [DATE] at 3:25 PM, the ice machine in a room on 100 Hall after being cleaned had black flakes on the ice. There was still wet black residue inside the interior surfaces of the ice machine. At 3:30 PM, CNA #1 pushed a cart that contained an ice chest toward the ice machine room to obtain ice for the water pitchers in the residents' rooms. The ice scoop holder hanging on the left side of a cart where ice chest was kept had approximately ,[DATE] cup of water standing in it. The bottom of the scoop holder had brown discolored residue settled on it. The ice scoop that was being stored in the scoop holder was in direct contact with the residue. Dietary Employee #1 was asked to empty out water from the scoop holder and to wipe the brown discolored residue settled at the bottom of the ice scoop holder. He did so, and brown discolored residue easily transferred to the paper towel. FSS was asked to describe the appearance of the scoop holder and how much water was in the scoop holder. He stated, Black/brown slimy residue. It had about ,[DATE] cup of water.
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** Based on record review and interview, the facility failed to ensure face mask were worn to cover the mouth and nose to prevent potential development and transmission of COVID-19 and other communicable diseases and failed to ensure handwashing was conducted during resident care to prevent the potential spread of infection in 1 of 1 facility. These failed practices had the potential to affect all 70 residents residing in the facility as documented on the Resident Census and Conditions of Residents form dated 8/31/2020. The findings are: 1. On 9/2/20 at 7:05 a.m., Licensed Practical Nurse (LPN) #3 was sitting at the nurse station with her surgical mask below her nose. She was asked, Should your mask be covering your nose? She stated, I fixed it, it is. 2. Resident #22 had [DIAGNOSES REDACTED]. The Admission MDS with an ARD of 6/15/2020 documented the resident was severely impaired in cognitive skills for daily decision making per a staff assessment for mental status required extensive assistance of one with eating, received tube feeding (TF) portion of calories 51% or more, and average fluid intake of 500cc (cubic centimeter) or more. On 09/01/20 at 10:00 AM, LPN #1 disconnected the TF and paused the pump during transfer to the Geri-Chair via mechanical lift. LPN used the controls of the lift, pushed the lift into the hallway, came back into the room and reconnected the TF and set the pump to run. She completed all these tasks, using the same gloves. At 10:08 a.m. LPN #1 was asked, Should you have washed or sanitized your hands before you reconnected the [DEVICE]? She stated, Yes ma'am, I'm sorry. 3. On 9/2/2020 during medication administration at 7:48 a.m., LPN #4 was asked, When should your hands be sanitized? She stated, Between residents. She was asked, Did you sanitized before Resident #65 medicines? She stated, No I did not. 4. On 9/4/2020, a review of the hand hygiene guidelines documented, .Decontaminate hands after contact with an inanimate object, after removing gloves and before and after contact with a resident intact skin such as lifting a resident .
F 0883 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Develop and implement policies and procedures for flu and pneumonia vaccinations.** Based on record review and interview, the facility failed to ensure Influenza and Pneumococcal immunization records were completed, for 3 (Residents #22, #36 and #65) of 5 (Residents #22, #1, #65, #44 and #36) sampled residents whose immunization records were reviewed. This failed practice had the potential to affect all 70 residents who resided in the facility, as documented on the Resident Census and Conditions of Residents form dated 8/31/2020. The findings are: 1. The Policy and procedure for the Influenza and Pneumococcal immunizations received from the Administrator on 8/31/20 at 12:38 p.m. documented, .If the resident and/or responsible party refuses the administration of the vaccine then they will be contacted on an annual basis and again educated on the risks and benefits of the immunizations. Another consent or refusal may be obtained . 2. On 9/01/20 at 9:15 a.m., the immunization records in the facility's Electronic Health Record (EHR) system were reviewed for 5 sampled residents with the following observations: Resident #22 Admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 6/22/2020 documented the resident wasn't offered the pneumococcal vaccine. Resident #36 Quarterly MDS with an ARD of 6/2/2020 documented the resident refused the pneumococcal vaccine. On 9/01/20 at 11:10 AM, The Director of Nursing (DON) provided consent form signed 9/26/19. 3. At 9/01/20 at 9:38 a.m., Resident #65 flu and Pneumococcal were documented as refused. The DON was asked for education on 9/1/2020 at 11:10 a.m. The DON stated she was still looking for the education/consent form. As of 9/4/2020 at 8:33 a.m., no consent had been provided.