STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045277	A. BUILDING _____ B. WING _____	07/02/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ARKANSAS CONVALESCENT CENTER	6301 SOUTH HAZEL STREET PINE BLUFF, AR 71603

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 0644 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to ensure that a Pre-Admission Screening And Resident Review (PASARR) was completed and on file in the facility for 1 (Resident #13) of 3 (Residents #2 #53 and #75) sampled residents with a [DIAGNOSES REDACTED]. (diagnosis) Of [MEDICAL CONDITION] provided by the Assistant Director of Nursing (ADON) on 07/02/20. The findings are: Resident #13 had [DIAGNOSES REDACTED]. a. On 7/02/20 at 03:30 PM, the entity that does PASARR testing was contacted and was told the resident was not in the system. The resident was diagnosed with [REDACTED]. There was documentation found that documented the facility had inquired about a Level II PASARR. The Director of Nursing ((DON)), was asked about the PASARR for the Resident. She stated, They could not find a Level II for this resident in the facility. b. On 07/02/20 at 03:50 PM, the ADON was asked if they had contacted the PASARR entity before today to inquire about the resident's PASARR status. She stated, No I did not call on him. At 03:55 PM the Director of Nursing (DON) was asked the same question and she stated, No I have not called on him. c. The Facility's Policy and Procedure for PASARR documented, The Facility's Admission Coordinator with the discharge planner or his/ (and or) her designee regarding [DIAGNOSES REDACTED].PASARR, the discharge planner is made aware that the potential admission requires a .PASARR. The .PASARR is obtained by discharge planner. The facility receives the final decision from discharge planner per .PASARR. The facility receives a copy of .PASARR from the discharge planner. The resident is then admitted upon arrival to facility. The DON/designee notifies PASARR entity of resident arrival . If approved for a certain amount of days, another 787 (form) is completed before the end of the time frame and re-submitted to PASARR entity for approval from PASARR entity. If level 2, a visit will be made by PASARR entity, and decision will be made, if approved, the resident is admitted .
F 0656 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to ensure the Comprehensive Care Plan included the development and implementation of interventions relating to oxygen therapy for 1 (Resident #226) of 4 (Residents #46, #50, #71 and #226) sampled residents who had physician's orders [REDACTED]. The findings are: 1. Resident #226 had [DIAGNOSES REDACTED]. She was on Hospice and was totally dependent on staff for care. a. A Comprehensive Care Plan dated 05/04/2020 did not address oxygen therapy or proper care and storage of oxygen tubing and nasal cannula. b. A physician's orders [REDACTED].Oxygen @ (at) 2-4 LPM (Liters Per Minute) via NC (Nasal Cannula) as needed for SOB (Shortness of Breath) . c. A physician's orders [REDACTED].Change NC and H2O (water) Bottle Q (every) Sunday every night shift . d. On 06/29/2020 at 11:17 A.M., Resident #226 was lying on her back in bed with eyes closed. She was receiving O2 (Oxygen) at 3L (Liters) per nasal cannula. e. On 06/30/2020 at 10:34 A.M., Resident #226 was lying on her back in bed with eyes open. She was receiving O2 at 3L per nasal cannula. f. On 07/01/2020 at 11:04 A.M., the Minimum Data Set (MDS) Coordinator was asked, Should oxygen therapy and maintenance be addressed in the care plan? She stated, I haven't been putting it in there because they mark it off on the MAR (Medication Administration Record), but that sounds like a good idea. I'm going to talk to my DON .
F 0657 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure a resident's care plan was revised to address the care and monitoring required to promote continuity of care for a [DIAGNOSES REDACTED].#2 and #20) of 4 (Residents #2, #7, # 20, and #30) sampled residents who had a [DIAGNOSES REDACTED].#13) of 1 sampled resident who had a lap buddy in use; the therapeutic and potential adverse effects of an antipsychotic medication, [MEDICATION NAME] for 1 (Resident #20) of 2 (Residents #29 and #74) sampled residents who had a physician order [REDACTED]. 1. Resident #2 had a [DIAGNOSES REDACTED]. a. A Physician order [REDACTED]. b. A Care Plan, dated as revised 07/01/2020, had no interventions documented for the care and treatment of [REDACTED]. c. On 07/2/20 at 3:27 P.M., the Minimum Data Set (MDS) Coordinator was asked, I was told by the Director of Nursing (DON) that you are the one who does the care plans. Is that correct? She stated, Yes, but others do as well, but I do it. She was asked, Is staff made aware of what to monitor the resident for by the care plan? She stated, Yes. She was asked, If a resident has a [DIAGNOSES REDACTED].? She stated, Yes. She was asked, Tell me why? She stated, For us to monitor for increased side effects, increased behaviors in the resident and any changes in condition. She was asked, Every year? She stated, Yes She was asked, So, if a resident is admitted in January and in June the resident is diagnosed and treated for [REDACTED].? She stated, Yes, but if there is a significant change or anything, it's written on the care plan in the chart. Surveyor informed MDS coordinator that on 07/01/20, the resident's hard chart was reviewed and there were no interventions written on it for the treatment of [REDACTED]. care planned. 2. Resident #20 had [DIAGNOSES REDACTED]. A Quarterly MDS with an ARD of 04/15/20, documented the resident scored 12 (8-12 indicates moderately impaired) on a BIMS and had not received any antipsychotic medications. a. A Physician order [REDACTED]. b. On 07/01/20 at 9:46 A.M., a review of the care plan in the electronic clinical record had no documented interventions for [MEDICAL CONDITION] or the use of an antipsychotic medication, [MEDICATION NAME]. c. On 07/01/20 at 10:12 A.M., the resident's hard chart was reviewed and there was no documented interventions on the care plan for [MEDICAL CONDITION] or the use of an antipsychotic medication, [MEDICATION NAME]. d. On 07/2/2020 at 3:27 P.M., the MDS Coordinator was asked, If a resident is taking an antipsychotic, antidepressant or an antianxiety medication, should it be care planned? She stated, Yes. She was asked, Tell me why? She stated, Because of behaviors and we have to monitor for side effects. At 3:35 pm, the MDS Coordinator reviewed the electronic clinical record for this resident regarding [MEDICAL CONDITION] being care planned and she stated, No, it's not in here. 3. Resident #67 had a [DIAGNOSES REDACTED]. A Quarterly MDS with an ARD of 06/11/20 documented the resident scored 6 (0-7 indicates severely impaired) on the BIMS and received an antianxiety medication 7 out of 7 days during the

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 0657 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 1) look back period. a. A Physician order [REDACTED]. b. On 07/01/2020 at 2:33 P.M., the care plan in the resident's hard chart and electronic clinical record, dated as initiated 12/19/2019, was reviewed and had no documented interventions for the use of [MEDICATION NAME] for the [DIAGNOSES REDACTED]. c. On 07/2/2020 at 3:27 P.M., the MDS Coordinator was asked, If a resident has a [DIAGNOSES REDACTED].? She stated, Yes. She was asked, Tell me why? She stated, Because it affects the resident's stay here. It can cause an increase in behaviors and we monitor for side effects. 4. Resident #13 had [DIAGNOSES REDACTED]. The Annual MDS with an ARD of 4/9/20 documented a score of 05 (indicates severely impaired) on a BIMS, was totally dependent for activities of daily living self-performance skills with 1-2 person physical assist. a. On 06/29/20 at 12:10 P.M., the Resident #13 was in his room in a Geri-chair. There was a Lap Buddy on the Geri-chair, it was not across the Geri-Chair but to the side near the right leg. b. On 07/02/20 at 3:10 P.M., Licensed Practical Nurse (LPN) #1 was asked about the lap buddy on the resident's Geri-chair. She stated, It is not placed across him, we put it on the side to pad the side of the Geri-chair because he sometimes pushes that right leg out to the side of the Geri-chair. When asked do you think that should have been care planned. She stated, Yes, it should have. c. On 07/02/20 at 3:50 P.M., the Director of Nursing was asked if the lap buddy being used for cushioning/ (and or) padding be added to the care plan. She stated, Yes it should, and there should not have been a lap buddy even in the building. I have talked to the one that put it there and have also done an in-service on it. 5. The Facility's Policy and Procedure for Updating Care Plans documented, After the DON or her designee reviews all new orders. The orders are reviewed by the MDS Manager. The MDS manager will communicate with medical records who adds new orders to the care plan. The DON/Designee will audit weekly that the appropriate orders were updated on the care plan.
F 0677 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide care and assistance to perform activities of daily living for any resident who is unable.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interview, the facility failed to ensure fingernails were cleaned and trimmed to promote good personal hygiene and grooming for 1 (Resident #20) of 15 (Residents #2, #7, #13, #20, #29, #30, #32, #46, #50 #53, #67, #71, #74, #75, and #226) sampled residents who were dependent for nail care. This failed practice had the potential to affect 76 residents who were dependent for nail care, as documented on a list provided by the DON (Director of Nursing) on 07/01/2020 at 11:03 AM. Resident #20 had [DIAGNOSES REDACTED]. A Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 04/15/20, documented the resident scored 12 (8-12 indicates moderately impaired) on the Brief Interview for Mental Status (BIMS) and required one-person extensive assistance for personal hygiene and one-person physical help in part of the bathing activity. a. A Care Plan, dated as reviewed 04/15/2020 in the resident's hard chart, documented, . Focus . (Resident #20) HAS an ADL (Activities of Daily Living) Self-Care Performance Deficit r/t (related/to) Abnormal Mobility Left Side Weakness R/T [MEDICAL CONDITION]/[MEDICAL CONDITION] . Interventions . BATHING: Check nail length and trim and clean on bath day and as necessary. Report any changes to the nurse . There was no documentation on the care plan in the electronic clinical record or the hard chart of the resident refusing nail care. b. On 06/29/20 at 11:53 A.M., the resident was resting in bed, awake, and surveyor noted her fingernails were greater than 1/4 inch in length and had a dark substance underneath. She was asked, Do you like your fingernails long? She stated, No. My sisters used to come in and take care of them but since whatever this is has been going around, they hadn't been able to come in here and do them. She was asked if the staff takes care of cleaning them and she stated, No, they hadn't. c. On 07/01/20 at 10:12 A.M., record review of the resident's Progress Notes from 3/30/20 to 07/01/20 did not document the resident refusing nail care. d. On 07/01/2020 at 11:50 A.M., Certified Nursing Assistant (CNA) #2 was asked, Who is responsible for trimming and cleaning the resident's fingernails? She stated, We are. She was asked, When is it done? She stated, As needed. She was asked, Is this documented in the resident's paper or electronic record, when it's done? She stated, Yes, in the ADL (Activities of Daily Living) book. She was asked, When is (Resident #20's) bath days? She stated, Tuesday, Thursday, Saturday. She was asked, Has she ever refused nail care? She stated, Yes, she don't let us cut her nails. She was asked, Is this documented somewhere? She stated, It's not a place on our paperwork that says refused, we just slash if we do it. I'll check them and if they need it, and we ask her, she says we can't cut her nails, so I just see if they are dirty or not. She was asked, If a resident refuses nail care, what do you do? She stated, I report it to the nurse and tell them that she won't let us cut her fingernails. e. On 07/02/2020 at 4:13 P.M., the facility's 24 Hour Report Sheets from 06/24/20 on the 6 a.m. to 2 p.m. shift through 07/01/20 on 2 p.m. to 10 p.m. shift were reviewed and there was no documentation of the resident refusing nail care.
F 0687 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide appropriate foot care.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interview, the facility failed to ensure toenails were cleaned and trimmed to promote good foot care for 1 (Resident #50) of 15 (Residents #2, #7, #13, #20, #29, #30, #32, #46, #50, #53, #67, #71, #74, #75, and #226) sampled residents who were dependent for nail care. This failed practice had the potential to affect 76 residents who were dependent for nail care, as documented on a list provided by the DON (Director of Nursing) on 07/01/2020 at 11:03 AM. 1. Resident #50 had a [DIAGNOSES REDACTED]. The Annual Minimum Data Set ((MDS) dated [DATE] documented the resident scored 06 (0 to 7 indicates severely impaired in cognitive skills) on a Brief Interview Mental Status (BIMS) and required extensive physical assistance of one person for personal hygiene. a. A physician's orders [REDACTED].Treatment Nurse to assess/trim (residents') nails Q (every) week and report any complications to Physician .every day shift every 7 days . b. The Comprehensive Care Plan dated 07/01/19 documented, .Refer to podiatrist/foot care nurse to monitor/document foot care needs and to cut long nails . c. On 06/29/2020 at 1:09 P.M., Resident #50 complained that her feet were hurting. Licensed Practical Nurse (LPN) #1 entered the room from the hallway and began to assess the resident's feet. The skin on the resident's feet was dry and peeling and all her toenails were overgrown approximately one fourth inch and in need of trimming. (Photo taken of right foot.) LPN #1 was asked, How often is nail care performed? She stated, At least once a week or whenever needed. She was asked, Would you say this resident's toenails need trimming? She stated, Yes. She was asked, Whose responsibility is it to provide nail care? She stated, The Nurses, Certified Nursing Assistants (CNA), the Treatment Nurse, sometimes the DON will do it . d. 06/29/2020 at 1:12 P.M., the Treatment Nurse entered the room with a cream for the resident's feet and was asked to look at the resident's toenails. She was asked, Would you say her (Resident #50) nails need trimming? She stated, Yes. She was asked, How often is nailcare provided? She stated, Whenever they get a bath or shower. She was asked, Whose responsibility is it? She stated, All of ours, the CNAs, Nurses, and I do some of them, whoever is giving her a bath can do them .but I can go ahead and trim them now . Surveyor took a photograph of Resident #50's toenails at this time. e. On 06/30/20 at 2:00 P.M., Resident #50 stated, My toenails been cut . LPN #1 was standing in the hallway and stated, . (Treatment Nurse) trimmed them for her yesterday . LPN #1 was asked, Who is responsible for nail care for diabetic residents? She stated, (Treatment Nurse) usually does theirs, but any nurse can. CNAs can't do the diabetics' nail care . f. On 06/30/20 at 2:08 P.M., CNA #1 was asked, How often is nail care provided? She stated, Whenever we give them a bath. She was asked, Whose responsibility is it to provide nail care? She stated, The nurses if they're diabetic, but the CNAs can do everybody else. She was asked, What would you do if you saw a resident in need of nail care? She stated, Tell the nurse . g. 07/01/2020 at 9:10 A.M., the DON was asked, How often is nailcare provided? She stated, They're trimmed once a week, but they're cleaned every time they get a bath. She was asked, Who is responsible for providing nailcare? She stated, The Nurses and Treatment Nurse does the diabetics just in case there's a complication and the CNAs can do the rest. h. The Policy and Procedure for Nailcare provided by the DON documented, .Residents with diabetes are seen by treatment nurse weekly for assessment and trimming of nails .Residents with no potential issues, their nails are trimmed by qualified personnel .In the event that a resident's nails cannot be safely trimmed by staff, the facility will make efforts for resident to be seen by specialist .
F 0695 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide safe and appropriate respiratory care for a resident when needed.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to ensure oxygen tubing and humidifier were labeled with date placed in use and tubing and nasal cannula were properly stored when not in use to minimize risks of infection for 2 (Residents #226 and #71) of 4 (Residents #46, #50, #71 and #226) sampled residents who had physician's orders [REDACTED].M. 1. Resident #226 had [DIAGNOSES REDACTED]. She was on Hospice and was totally dependent on staff for care. The MDS did not document the use of oxygen. a. A Comprehensive Care Plan dated 05/04/2020 did not address oxygen therapy or

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F 0695 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 2) proper care and storage of oxygen tubing and nasal cannula. b. A physician's orders [REDACTED].Oxygen @ (at) 2-4 LPM (Liters Per Minute) via NC (Nasal Cannula) as needed for SOB (Shortness of Breath) . c. A physician's orders [REDACTED].Change NC and H2O (water) Bottle Q (every) Sunday every night shift . d. On 06/29/2020 at 11:17 A.M., Resident #226 was lying on her back in bed with eyes closed. She was receiving O2 (oxygen) at 3 Liters (L) per nasal cannula. The oxygen tubing and the humidifier were not labeled or dated. There was no bag or other container available for storage. e. On 06/30/2020 at 10:34 A.M., Resident #226 was lying on her back in bed with eyes open. She was receiving O2 at 3L per nasal cannula. The oxygen tubing and the humidifier were not labeled or dated. There was no bag or other container available for storage. f. On 06/30/20 at 3:18 P.M., the DON was asked to accompany surveyor to resident's room. She was asked, Can you find a date on the tubing or humidifier? She stated, No. She was asked, Should the tubing be labeled with a date showing when it was last changed? She stated, Yes. She was asked, Should a storage bag be available for storage of the tubing and nasal cannula when oxygen is not in use? She stated, Yes. When she was unable to locate a storage bag she was asked, Who is responsible for proper labeling of the tubing and humidifier and ensuring that a storage bag is available? She stated, The night shift should do it on Sunday nights, but any of the nurses should make sure it's done if it hasn't been. She was asked, Is there a reason (Resident #226's) tubing has no label and no storage bag is available? She stated, No, I don't know why . g. On 07/01/2020 at 2:56 P.M., Licensed Practical Nurse (LPN) #2 was asked, Should the oxygen tubing and humidifier be labeled with the date it was last changed? She stated, Yes. She was asked, Should a storage bag be available for storage of the tubing and nasal cannula when not in use? She stated, Yes. She was asked, Who is responsible for ensuring these things are done? She stated, I think it's done on night shift on Sunday and Wednesday nights if I'm not mistaken . She was asked, What should you do if you saw that it hadn't been done? She stated, I would do it. 2. Resident #71 had [DIAGNOSES REDACTED]. A Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 04/06/2020 documented the resident scored 15 (12-15 indicates cognitively intact) on the Brief Interview Mental Status (BIMS) and received oxygen therapy while a resident. a. A Physician order [REDACTED]. There was no order documented to change the O2 connector tubing. b. A Care Plan, dated as initiated 07/20/2019 documented: . Focus . (Resident #71) HAS altered respiratory status/Difficulty Breathing r/t (related/to) Anxiety And Sleep Apnea At Night An [MEDICAL CONDITION] Hypertension . Interventions: . [MEDICAL CONDITION] (Bilevel Airway Positive Pressure)/[MEDICAL CONDITION]/VPAP (Variable Positive Airway Pressure) SETTINGS: My ([MEDICAL CONDITION]/[MEDICAL CONDITION]) settings are- Titrated pressure (sic): (X)cmH2O via (by way of) (nasal pillow, nose mask or full-face mask) . Provide oxygen as ordered . c. On 06/30/2020 at 9:06 A.M., Resident #71 was sitting in a recliner in her room, resting quietly. There was an oxygen concentrator in the corner on and set at 1 L/M (liters/minute) that was connected to her [MEDICAL CONDITION] machine. The [MEDICAL CONDITION] mask was laying on the pillow on her bed and not stored. The O2 tubing was dated 06/10/20. She was asked, Do the nurses come in and turn on your oxygen machine? She stated, I'm a retired nurse and I know how to work everything. I just click the button on when I need to use it. d. On 06/30/2020 at 4:07 P.M., the resident's June 2020 electronic Medication Administration Record [REDACTED]. e. On 07/02/2020 at 3:44 P.M., the Director of Nursing (DON) was asked, How often is the O2 tubing that connects (Resident #71's) oxygen concentrator to the [MEDICAL CONDITION] machine changed? She stated, Weekly. She was asked, Who is responsible for setting liter flow on the concentrator? She stated, The licensed nurse. She was asked, Who monitors this to ensure it is on the correct rate? She stated, The licensed nurse. She was asked, Does the resident adjust the flow of O2 on the concentrator? She stated, Yes ma'am. She was asked, Is this care planned? She stated, It should be. 3. The Policy and Procedure for Oxygen Therapy Maintenance provided by the DON documented, .Tubing and /or humidifying bottles are changed out weekly and as needed. Oxygen tubing equipment is dated. Tubing is placed in bag and dated when not in use .
F 0758 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure an antipsychotic medication, [MEDICATION NAME], was prescribed with an appropriate [DIAGNOSES REDACTED].#20) of 2 (Residents #20 and #74) sampled residents who had a physician order [REDACTED].#67) of 4 (Resident #7, #32, #46, and #67) sampled residents who had a physician order [REDACTED]. Resident #20 had [DIAGNOSES REDACTED]. A Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 4/15/20, documented the resident scored 12 (8-12 indicates moderately impaired) on a Brief Interview for Mental Status (BIMS) and had not received any antipsychotic medications. a. The Physician order [REDACTED]. b. The Physician's Progress Notes in the resident's hard chart dated 06/05/20, documented, Telemedicine Visit 10:00 - 11:15 AM . Still accusing staff of stealing (and) not administering her meds (medications) . Plan: [MEDICATION NAME] 5 mg (milligrams) . for DX: (diagnosis) F01.51 . The resident's attending physician's signature was on the bottom of the note. The Medication [DIAGNOSES REDACTED]. c. On 07/01/2020 at 10:09 a.m., the resident's progress notes for 03/30/20 to 07/01/20 documented, 1) . 4/22/2020 11:00 (11:00 am) Nurses Note Text: Resident approached this nurse aide wanting to know why we don't like her and stating that she heard we wanted to kill her. Resident was reassured that we all like her and no one has said anything about her. Social was notified and ADON (Assistant Director of Nursing). There has been a call put in for (Doctor's Name). 2) . 5/22/2020 08:20 (8:20 am) Type: Nurses Note Resident refused all morning meds. Medications were wasted and MD (medical doctor) notified. Stated to continue to monitor.; 3) 6/9/2020 07:50 (7:50 am) eMar (electronic medication administration record)- Medication Administration Note Text: [MEDICATION NAME] Tablet 5 MG Give 1 tablet by mouth one time a day related to [MEDICAL CONDITION] With Behavioral Disturbance . There were no further behaviors charted for this resident as of 7/01/2020 at 8:13 pm. d. On 07/01/2020 at 4:05 p.m., the resident's hard chart was reviewed and there was no consultation report or any documentation clarifying the use of [MEDICATION NAME]. e. On 07/02/2020 at 3:44 p.m., the DON was asked, (Resident #20) is on the medication [MEDICATION NAME]. What is the clinical indication for this med? She stated, [MEDICAL CONDITION]. She was asked, Is [MEDICAL CONDITION] an appropriate [DIAGNOSES REDACTED].? She stated, Yes ma'am, according to her physician who has been a physician for over [AGE] years. She was asked, How do you determine what behaviors to monitor the resident for? She stated, We monitor and assess the resident before they are put on anything and notify the physician of what the behaviors are, and he/she will order the appropriate meds. When they are put on meds, we monitor them for changes such as a decrease in agitation or weight loss. 2. Resident #67 had a [DIAGNOSES REDACTED]. A Quarterly MDS with an ARD of 6/11/20 documented the resident scored 6 (0-7 indicates severely impaired) on a BIMS and received an antianxiety medication 7 out of 7 days during the look back period. a. A Physician order [REDACTED]. b. A Consultation Report dated 06/01/20 documented, . (Resident #67) has received [MEDICATION NAME] 0.25 mg PO twice a day since 12/26/2019. Recommendation: Please attempt a gradual dose reduction (GDR) to [MEDICATION NAME] 0.5 mg tab Give 0.5 mg tablet (0.25 mg) po (by mouth) Q (every) PM (evening) (DC (discontinue) AM (morning) dose), while concurrently monitoring for reemergence of target behaviors and / or withdrawal symptoms . The physician checked the box that documented, I accept the recommendation(s) above, please implement as written. The physician also checked the box I decline the recommendation(s) above because GDR (Gradual Dose Reduction) is clinically contraindicated for this individual as indicated below. (NOTE: Please check option #(number)1 or #2 AND provide patient-specific rational on the lines below.) Continued use is in accordance with the current standard of practice and a GDR attempt at this time is likely to impair this individual's function or cause psychiatric instability by exacerbating an underlying medical condition or psychiatric disorder AS DOCUMENTED BELOW, -OR- . The physician failed to document a patient specific rational for declining the recommended gradual dose reduction. The form was signed and dated 6/5/2020. On the resident's Medication Regimen Review form, it was documented, 12/20 (+) (add) [MEDICATION NAME] 0.25 mg Q day 12/26 (increase) [MEDICATION NAME] 0.25 mg BID (twice a day) . c. On 07/02/20 at 11:45 a.m., the DON was asked to provide any GDRs for this resident for [MEDICATION NAME]. At 1:20 pm, the DON brought a Consultation Report dated 06/01/20, that surveyor had previously reviewed, which had no clinical indications listed by the physician as a reason to not perform the GDR for [MEDICATION NAME]. d. A Policy and Procedures Gradual Reduction of Medications, provided by the DON on 7/2/20 at 1:20 p.m., documented, . The purpose of tapering a medication is to find an optimal dose or to determine whether continued use of a medication is benefiting a resident .

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045277	A. BUILDING _____ B. WING _____	**07/02/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ARKANSAS CONVALESCENT CENTER	**6301 SOUTH HAZEL STREET PINE BLUFF, AR 71603**

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 0758 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 3)
F 0803 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident.** Based on observation, record review and interview, the facility failed to ensure pureed and mechanical soft meals were prepared and served according to the planned written menu to meet the nutritional needs of the residents for 1 of 1 meal observed. This failed practice had the potential to affect 13 residents who received mechanical soft diets and 13 residents who received pureed diets, according to the Diet List provided by Food Service Supervisor on 07/02/2020. The findings are: 1. On 07/01/2020, the menu for the noon meal documented residents on regular and mechanical soft diets were to receive 3 ounces (oz) of pork lions. Residents on pureed diets were to receive a #8 scoop (4 oz) of pureed pork loins. a. On 07/01/2020 at 11:14 A.M., Dietary Employee #3 placed 7 servings of pork loins into a blender, ground the pork loins, poured the contents into a pan and placed it on the steam table for the residents on mechanical soft diets. At 1:30 pm Dietary Employee #3 was asked, How many servings of pork loins did you prepare for the residents on mechanical soft diets. She stated, I did 15 ounces. She was asked, How many residents do you have on mechanical soft diets. She stated, We have 13 residents. They should have gotten 39 ounces since the menu said 3 ounces each. b. On 07/01/20 at 11:21 A.M., Dietary Employee #3 placed 3 large servings and 6 small pieces of pork loins into a blender. At11:24 am, when she was ready to add broth, she was asked by surveyor to weigh the 3 large pork loins. She did so. The first one weighed 5 oz, second one weighed 4 oz and the third one weighed 3 oz. She stated, I have 12 ounces. She added broth, 11 tablespoons of thickener and pureed. At 11:27 am she poured pureed pork loins into a pan on the steam table. c. On 07/01/20 at 12:10 P.M., there was no bread prepared and served to the residents on pureed diets. Dietary Employee #3 served pureed trays without any type of bread. At 1:30 pm, Dietary Employee #3 was asked what the reason was that the residents on pureed diets did not have any type of bread. She stated, We were told by our former supervisor not to give bread to the residents on pureed diets. We just discussed this on Monday. Our Director of Nursing told us to start giving bread to the residents on pureed. When she was asked if bread was given to them at the lunch meal. She stated, No. d. On 07/01/20 at 1:30 P.M., Dietary Employee #3 was asked, How many servings of pork loins did you prepare for the residents on mechanical soft diets. She stated, I did 15 ounces. She was asked, How many residents do you have on mechanical soft diets. She stated, We have 13 residents. They should have gotten 39 ounces since the menu said 3 ounces each. When asked how many servings did she prepare for the residents on pureed diets. She stated, When you asked me to weigh the 3 large pieces I had put into a pan, I did and the first one weighed 5 ounces, second one weighed 4 ounces and the third one weighed 3 ounces. That was total of 12 ounces, the remaining small pieces left in the pan were 8 ounces because they were small pieces. So, I did 20 ounces for the pureed. They should have gotten 39 ounces since the menu said 3 ounces each e. On 07/02/2020 at 7:17 A.M., the Dietary Supervisor was asked how much mechanical soft meat was left in the pan after serving the lunch meal on 07/01/2020. She stated, We had 4 servings of ground meat left in the pan that were not served. She was asked, should you have had anything left? She stated, No. We had none left on pureed.
F 0804 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to ensure meals were served at temperatures that were acceptable to the residents, to improve palatability and encourage good nutritional intake during 1 of 1 meal observed. This failed practice had the potential to affect 11 residents who received meal trays in their rooms on 100 hall, 8 residents who received meal trays in their rooms on 200 hall, 15 residents who received meal trays in their rooms on 300 hall, 11 residents who received meal trays in their rooms on 400 hall and 15 residents who received meal trays in their room [ROOM NUMBER] Hall, as documented on list provided by Food Service Supervisor on 7/2/2020. The findings are: 1. Resident #20 had a Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 4/6/20 documented the resident scored 12 (8-12 indicates moderately impaired) on the Brief Interview for Mental Status (BIMS). a. On 6/29/20 at 11:53 am, Resident #20 was sitting up in bed. She was asked, How is the food here? She stated, My food is cold when I get it. She was asked, Can you tell me what in particular is cold? She stated, All of it. It doesn't be warm when they get it to you. She was asked, Is it a particular meal? She stated, Really, I don't like none of it but, I try to eat enough of it to stay alive. 2. Resident #71's Quarterly MDS with an ARD of 4/6/20 documented the resident scored 15 (13-15 indicates cognitively intact) on the BIMS. a. On 6/30/20 at 9:00 am, Resident #71 stated, My one big complaint is cold eggs. I have just about turned away from eggs because I can't eat them. The bacon is too crispy and sometimes it's burned. 3. On 7/2/20 at 7:33 a.m., Certified Nursing Assistant (CNA) #1 delivered 2 unheated meal carts containing 4 breakfast trays on each cart for the 200 hall. At 7:45 a.m., immediately after the last resident received their tray in their room on the 200 Hall, the temperatures of the food items on the trays used as test trays were checked and read by CNA #1 with the following results: a. Whole milk - 49.8 degrees Fahrenheit. b. Scrambled eggs - 104.6 degrees Fahrenheit. c. Sausage with gravy - 97.5 degrees Fahrenheit. 4. On 7/2/20 at 7:41 a.m., CNA #2 delivered an unheated tray cart containing 12 breakfast trays for the 600 hall. At 7:53 a.m., immediately after the last resident received their tray in their room on the 600 Hall, the temperatures of the food items on the trays used as test trays were checked and read by CNA #4 with the following results: a. Whole milk - 49.6 degrees Fahrenheit. b. Regular sausage - 102.4 degrees Fahrenheit. c. Scrambled eggs - 105.6 degrees Fahrenheit. d. Ground sausage with gravy - 99.0 degrees Fahrenheit. 5. On 7/2/20 at 7:50 a.m., CNA #3 delivered an unheated tray cart containing 4 breakfast trays for the 100 hall. At 7:52 a.m., CNA #5 delivered another an unheated tray cart containing 4 breakfast trays for the 100 hall. At 7:59 a.m., immediately after the last resident received their tray in their room on the 100 Hall, the temperatures of the food items on the trays used as test trays were checked and read by CNA #5 with the following results: a. Pureed eggs -111 F
F 0812 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.** Based on observation and interview, the facility failed to ensure foods stored in the storage room were maintained to prevent potential for cross contamination and failed to ensure dietary staff washed their hands between dirty and clean tasks and before handling clean equipment or food items to minimize the potential for food borne illness for residents who received meals from 1 of 1 kitchen. The facility failed to ensure freezer temperature was maintained at 0 degrees Fahrenheit or below to maintain the quality of frozen foods and to prevent the growth of microorganisms and failed to ensure thawed dinner rolls were not refrozen to prevent the risk of bacterial growth. These failed practices had the potential to affect 75 residents who received meals from the kitchen (total census: 76) as documented on a list provided by the Food Service Supervisor on 07/2/2020. The findings are: 1. On 06/29/2020 at 11:10 AM, the following observations were made in the storage room: a. A box of grits on a shelf in the storage room was not sealed closed. b. A bag of gravy on a shelf in the storage room was not sealed closed. 2. On 07/01/20 at 10:14 a.m., the following observations were made in the kitchen area: a. Dietary Employee #4 pulled his pants up and did not wash his hands before he picked up clean glasses by their rims and poured beverages to be served to the residents for lunch. At 1:27 pm Dietary Employee #4 was asked, What should you have done after touching dirty objects before handling clean equipment? She stated, Washed my hands. 3. On 07/01/20 at 10:29 a.m., Dietary Employee #2 turned on the 2 compartments sink with her hand and obtained water in a measuring cup, she then turned off the faucet. Dietary Employee #2 did not wash her hands before she picked up a clean blade and attached it to the blender to be used in pureeing food items to be served to the residents who required pureed diets. 4. On 07/01/20 at 10:56 a.m., the temperature was 26 degrees Fahrenheit and the following food items were not frozen solid: a. There were 12 bags of mixed vegetables and a bag of English peas stored above the air vent that were soft to touch. b. There were 8 bags of pancakes inside the door shelf that were soft to touch. Dietary Supervisor stated, We had the door open on Friday to load our groceries. Maybe they did not close the door properly. 5. On 7/01/20 at 11:10 a.m., Dietary Employee #2 took out a bag of dinner rolls from the freezer and kept it on a rack by the stove. She removed dinner rolls from the bag and placed them in two pans and then placed them in the oven. At 12:19 p.m., the bag of dinner rolls was still on the rack and was soft to touch. At 4:54 pm, the bag of dinner rolls that was left on a rack by the stove was in the deep freezer. They were stuck together and mushy to touch. The Dietary Supervisor stated, Once it's thawed, we can't

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F 0812 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Many	(continued... from page 4) refreeze it? a. On 07/02/2020 at 11:45 am, Dietary Employee #2 was asked, What time did you put the bag of dinner rolls back in the freezer? She stated, I put it back in the freezer at 1:00 pm. 6. On 7/01/20 at 12:00 pm, Dietary Employee #2 picked up a bag of bread from a rack by the stove and another bag from the bread rack in the storage room and placed them on the counter. She opened both bags, removed slices of bread from each bag and placed them on a piece of foil spread out on the counter. Dietary Employee #2 did not wash her hands before she reached into the bag and removed the slices of bread. She washed her hands, removed a packet of ham from the refrigerator, removed 2 slices from the packet and warmed it up in the microwave. Went to the storage room took out a packet of gravy and prepared gravy. Without washing her hands, she removed slices of ham and slices of cheese and placed them on each on slices of bread and topped them with another slice of bread. She wrapped each sandwich with a piece of foil to be served to the residents who requested a ham and cheese sandwich with their meal. 7. On 7/01/20 at 12:13 p.m., Dietary Employee #2 took out a cucumber and tomato from the refrigerator. She peeled the cucumber and sliced it and the tomato without rinsing them, then placed them into a bowl to be served to the resident who requested cucumber and tomato with their meal. Dietary Employee #2 stated, I should have rinse them.