STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045408	A. BUILDING _____ B. WING _____	03/13/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ALCOA PINES HEALTH AND REHABILITATION	3300 ALCOA ROAD BENTON, AR 72015

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 0584 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to ensure resident's equipment (geri-chairs) were maintained in clean condition to enhance the resident's quality of life for 1 (Resident #59) of 4 (Residents #59, 16, 19, and 20) sampled residents who required the use of a geri-chair for mobility. The failed practice had the potential to affect 5 residents who required a Geri-chair for mobility, according to a list provided by the Administrator on 3/12/20. The findings are: Resident #59 had [DIAGNOSES REDACTED]. A Quarterly Minimum Data Set with an Assessment Reference Date of 1/27/20 documented the resident scored 5 (0-7 indicates severe impairment) on a Brief Interview for Mental Status and required extensive assistance with two people for bed mobility and transfers, and was totally dependent with one person for locomotion off and on unit. 1. On 03/09/20 at 10:40 AM, the resident was awake and sitting in her geri chair. The Geri-chair had crumbs and old tape wadded up and stuck on the footrest of the chair. (Surveyor took a photo). 2. On 03/10/20 at 02:53 PM, resident was in bed and the geri-chair was in the hallway. Crumbs and old tape wadded up remained stuck on the footrest. (Surveyor took a photo). 3. On 03/12/20 at 08:18 AM, Certified Nursing Assistant (CNA) #1 was asked, Who cleans the geri chairs? She stated, The CNAs on night shift. 4. On 3/12/20 at 08:20 AM, the Director of Nursing (DON) was asked, Who cleans the geri-chairs? She stated, Staff. Normally CNAs on 11PM-7AM shift, but any staff can clean them if they need to be cleaned. She was shown the picture of the dirty geri-chair and asked, Does that look like it's dirty and need to be cleaned? She stated, Yes. 5. On 3/12/20 at 08:21 AM, the Assistant Director of Nursing (ADON) was shown the photo of the dirty geri-chair and was asked, Does that look like it's dirty and needs to be cleaned? She stated, Yes. 6. On 3/12/20 at 08:41 AM, the Administrator was shown the photo of the dirty geri chair and was asked, Does that look dirty and need to be cleaned? He stated, Yes. 7. A Wheelchair Cleaning Schedule provided by the ADON on 03/12/20 documented a daily cleaning schedule with wheelchair/geri-chairs to be cleaned weekly, with Resident #59's geri-chair to be cleaned on Fridays. 8. A policy titled, Cleaning and Disinfection of Environmental Surfaces provided by the DON on 03/12/20 at 11:53 AM documented, .Environmental surfaces will be cleaned and disinfected .
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 the rate flow on the Kangaroo Pump for water flushes was set at the rate as ordered by the Physician to promote hydration for 1 (Resident #198) of 2 sampled residents with Tube Feedings. The findings are: Resident #198 had [DIAGNOSES REDACTED]. The Nursing Admit/Readmit assessment dated [DATE] documented the resident was impaired in cognitive functioning and was totally dependent on staff for care. a. The Comprehensive Care Plan dated 03/05/2020 documented, .The resident requires tube feeding r/t (related/to) Dysphagia .Monitor/document/report PRN (as needed) any s/sx (signs/symptoms) of .dehydration .The resident is dependent with tube feeding and water flushes. See MD (Medical Doctor) orders for current feeding orders. b. A physician's orders [REDACTED].every shift Enteral Feed Order .[MEDICATION NAME] 1.5 (at) 50 ML (milliliters)/HR (hour) via Pump with H20 (water) flushes at 58 ML/HR . c. A physician's orders [REDACTED]. every shift Enteral Feed Order .[MEDICATION NAME] 1.5 (at) 50 ML/HR via Pump with H2O (water) flushes at 20 ML/HR . d. On 03/09/2020 at 10:24 AM, Resident #198's settings on the feeding pump were as follows: [MEDICATION NAME] 1.5 at 50 ml/hr and water flushes at 0 (zero) ml/hr. A photo was taken at this time. The label on the bag documented, .[MEDICATION NAME] 1.5 at 50 ml/hr and water at 58 ml/hr . e. On 03/09/2020 at 2:45 PM, Licensed Practical Nurse #3 was asked, What should the setting be for water flushes for (Resident #198)? She stated, She is at 20 ml/hr now She was asked, What was the rate flow before she was changed? She stated, She was at 58 ml/hr earlier. She was asked, Should the rate have been set at 0 ml/hr at any time for the water flushes? She stated, No. She was shown the picture taken at 10:24 AM on 03/09/2020. She stated, I don't know how that happened because I'm always checking the rates. She was asked, Could there be a negative impact on the resident's hydration status if the pump is set at 0 ml/hr? She stated, Yes, she wouldn't be getting water, but I can't tell you how that happened. f. On 3/13/2020 the Director of Nursing (DON) was asked, Who is responsible for monitoring the rates of flow for the enteral feed and the water on the feeding pumps? She stated, The nurses. She was asked, Should the rates of flow always be consistent with the current physician's orders [REDACTED]. She was asked, Should the rates of flow match what is written on the label on the bag? She stated, Yes. g. On 03/12/2020 at 3:51 PM, the Enteral Tube Feeding via Continuous Pump policy provided by the Nurse Consultant documented, .Purpose: .to provide a guideline for the use of a pump for enteral feed .General Guidelines .(3) .Check the following information . Rate of Administration (ml/hr) .
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 was administered at the flow rate ordered by the physician to reduce the potential for respiratory complications for 1 (Resident (R) #28) of 10 (R #21, #25, #28, #33, #40, #62, #63, #69, #88, and #91). The findings are: 1. Resident #28 had [DIAGNOSES REDACTED]. The Admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 01/10/2020 documented the resident scored 14 (13-15 indicates cognitively intact) on a Brief Interview for Mental Status (BIMS) had shortness of breath with exertion, shortness of breath when sitting, and received oxygen therapy. a. A physician's orders [REDACTED].Oxygen at 2 lpm (liter per minute) via (by) nasal cannula as needed. b. On 03/10/20 at 11:24 AM, at 1:05 PM, and at 2:56 PM, the resident's oxygen was on at 2.5 lpm via nasal canula. c. On 03/10/20 at 03:01 PM, Licensed Practical Nurse (LPN), was asked, What is his oxygen set on? She said, It's on 3 liters. She was asked, What is it supposed to be on? She said, I believe 2 liters. The resident said he turned it up to 4 liters. She was asked, Is he care planned to self-adjust oxygen? She said, No. d. On 03/12/20 at 11:43 PM, the Oxygen Administration procedure provided by the Director of Nursing documented, .The purpose of this procedure is to provide guidelines for safe administration .Steps in the Procedure #8 Adjust the oxygen delivery device so that it is comfortable for the resident and the proper flow of oxygen is being administered .Documentation #3 The rate of oxygen flow, route, and rationale.
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.** **Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.**

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 0812 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	(continued... from page 1) Based on observation and interview, the facility failed to ensure 2 ice machines were maintained in a sanitary condition and food was dated/stored to prevent the potential for food borne illness in 1 of 1 facility. This failed practice has the potential to affect 93 residents who received meals and 88 residents who receive ice from the kitchen. (total census: 97) The findings are: 1. On 03/09/2020 at 10:22 AM, the Dietary Manager wiped the inside of an ice machine in the kitchen with ungloved hands. As she wiped the crevice between the lid and the bin, a small light-colored insect dropped onto the ice. The Dietary Manager was asked, Did the insect come from the napkin? She replied, No, it had to have just fallen from somewhere. The crevice was filled with a buildup of blackish substance. (surveyor took a photo) 2. On 03/08/2020 at 10:40 AM, on a shelf in the dry storage there were three 28-ounce cans of diced pimentos that had dents that were 2 to 3 inches in depth. 3. On 03/08/2020 at 10:55 AM, the Dietary Manager wiped the inside of an ice machine in the nourishment room on hall 400 with ungloved hands. After wiping the splash shield with a white napkin there was a pinkish, brownish substances on the napkin. The Dietary Manager was asked, What do you see? She replied, Looks like a little buildup of brownish dirt. (surveyor took a photo) 4. On 03/08/2020 at 11:00 AM, in the nourishment room's refrigerator there was a 4-ounce carton of strawberry milkshake, 2 cartons of nectar thickened orange juice and 1 container of nectar thickened smoothie with no dates.
F 0825 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide or get specialized rehabilitative services as required for a resident.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interview, the facility failed to ensure specialized rehabilitation services were provided in accordance with professional standards of practice and as ordered for 1 (Resident (R) #96) of 2 sampled residents who had orders for Physical Therapy (PT). The findings are: 1. Resident #96 had [DIAGNOSES REDACTED]. The Admission Minimum (MDS) data set [DATE] documented the resident was cognitively impaired in skills for daily decision-making. a. On 09/10 2020 at 9:25 AM, during a telephone interview the son stated, My mother was admitted to the facility from another facility. Orders were sent with her for PT services by her surgeon. When the services were never started, I inquired about it and was told that the facility could not find the orders for PT. My mother had an appointment with the surgeon on 03/02/2020 so we asked if he would rewrite the orders for PT. He did and I called the facility to see if they got the orders and they said 'Yes' they got them . that was Monday a week ago and still no PT services have been started. He was asked, Do you know who it was that you spoke to who said they received the orders from the surgeon? He stated, I think it was (female name) in the DON's (Director of Nursing) office, I'm not sure of the name . b. On 3/11/2020 at 11:02 AM, the Director of Rehab was asked, Have you evaluated R #96 for PT or do you have her on your caseload? She stated, No, I'm not familiar with that name. I don't have her on my caseload. She was asked, How are you informed of residents who need PT or who have been referred by a Physician for PT? She stated, Usually the nurses will get that information and let me know, we then do a payor source form and a screening on them . c. On 03/10/20 at 11:15 AM, the DON was asked, Have you had any complaints or concerns from the family of R #96 about PT services not being started? She stated, No, I have talked to the son, but it was about financial matters. She was asked, Do you have a staff member named (female name)? She stated, No. She was asked, Are you aware that R #96 had an appointment with the surgeon on 03/02/2020? She stated, Yes. She was asked, Did the surgeon send orders back to the facility concerning his request to have PT services started for R #96? She stated, Not to my knowledge. I didn't have anything in my box about her. When the van driver brings orders back, she will put a copy in my and the ADON's (Assistant Director of Nursing) box so we are aware. She also gives a copy to the Medicare MDS (Minimum Data Set) Coordinator. We have been without a Unit Manager who would normally take the orders and scan them in. d. On 03/10/2020 at 12:35 PM, the Transportation Certified Nursing Assistant (CNA) #2 was asked, Did you take R #96 to an appointment on 03/02/2020 to see her surgeon? She stated, Yes. She was asked, Were you given orders from the surgeon's office on 3/2/20 to give to the facility? She stated, No. This is what I do, I give them my communication form and they write on it and sign it and I take it to back to the facility. She was asked, Did they write on the communication form? She stated, Yes, but they didn't sign it. She was asked, Did you give the form to anyone at the facility? She stated, No because they didn't sign it. She was asked, What did you did with the form? She states, I think it's in my files. She was asked, What are you supposed to do with paperwork that comes from the appointments? She stated, I'm supposed to give a copy to the DON or ADON, Charge Nurse and MDS. She was asked to go get the form. e. On 03/10/20 at 1:42 PM, the Transportation CNA #2 returned with the Communication form. The form had written information on it from the surgeon. She stated, It was in my paperwork to file, it was real busy and I guess I just forgot. I didn't give it to anybody and that's my fault, it was my responsibility to give it to them. She was asked, Were you trained about what you are supposed to do with the communication form or any paperwork that it sent back for the residents? She stated, Yes. f. On 03/10/2020 at 2:00 PM, Licensed Practical Nurse (LPN) #3 was asked, Were you the Nurse in Charge when R #96 went for an appointment to see the surgeon on 03/02/2020? She stated, Yes. She was asked, Did you receive the paperwork with instructions for PT when she returned?' She stated, No, the CNA gives that to the ADON, DON and MDS. She should have given a copy to therapy too. She was asked, Were you the nurse on duty when the resident was admitted ?' She stated, Yes. Did you receive the admission paperwork? She stated, Yes. Do you recall instructions for her to receive PT? She stated, Yes, it was written on the little slip of paper from a script (prescription) pad. She was asked, What happened to it? She stated, I gave all of it to the ADON to scan in, I thought it (orders for PT) had already been scanned in. g. On 03/12/20 at 11:13 AM, the ADON was asked, Do you recall receiving the admission paperwork for R #96 from the nurse to be scanned? She stated, Yes, I scanned it in. She was asked, The nurse recalls orders for PT on a slip of paper from a script pad, did you scan in the orders for PT? She stated, I don't recall scanning orders for PT. She was asked, Can you think what might have happened to the order? She stated, It may have gotten lost in the clutter on my desk, there is so much stuff on my desk . h. On 03/12/2020 at 4:00 PM, the DON was asked for a Policy or Procedure related to the proper handling of documents by Transportation CNAs and she stated, There is nothing written down .
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 observation, record review and interview the facility failed to ensure staff washed their hands before entering resident's room and administering medication for 1 (Resident (R) #85) of 6 sampled residents. Also failed to ensure staff wore/used gloves during the administration of medication to prevent potential contamination for 1 (Resident #63) of 1 sampled residents who received stock medications from Licensed Practical Nurse (LPN) #1. The findings are: 1. On 03/10/2020 at 8:28 AM during the morning medication pass, Licensed Practical Nurse (LPN) #3 advised the surveyor before she started that she would need to go to the medication room to get the [MEDICATION NAME]. She went to the medication room, unlocked the door and the locked box to get the medication then signed it out with the surveyor's ink pen. When she walked back to her cart, she dropped the pill on top of her medication cart when she tried to remove it from the package. She had to go back to the medication room and repeat the above steps to obtain the [MEDICATION NAME]. Once she put the pill in the cup she went to the resident's room and entered and administered the medication without washing or sanitizing her hands. a. On 03/10/2020 at 8:30 AM, LPN #3 was asked, Should you have washed your hands before entering the resident's room and administering medication after having gone to the locked medication room twice and used surveyor's ink pen to sign out the medications? She stated, Yes. b. On 3/13/2020 at 8:10 AM, the Director of Nursing (DON) was asked, Should the medication nurse wash or sanitize her hands before entering a resident's room and administering medication? She stated, Yes. 2. Resident #63 had [DIAGNOSES REDACTED]. a. The (NAME)2020 physician orders [REDACTED]. Sodium Chloride Tablet 1 gm (gram), Give 1 tablet by mouth with meals . b. On 03/11/20 at 07:41 AM, LPN #1 set up medications for Resident #63. She tilted the bottle of stock Aspirin [MEDICATION NAME] coated 81 milligrams. Two pills fell into the lid. LPN #1 put her bare finger on one of the pills while she tilted the lid back over the bottle and let the untouched pill fall back into the bottle. She then picked up the bottle of Sodium Chloride 1 gram. She tilted the bottle up. Two pills fell into the lid. She then put a bare finger on the pill and tilted the lid back, so the untouched pill fell back into the bottle. c. On 03/11/20 at 01:44 PM, LPN #1 was asked, Should you touch medications with your bare hands? She stated, No. d. On 03/11/20 at 02:01 PM, the DON was asked, Should a nurse touch medication with her bare hand? She stated, No, and shook her head. e. On 03/11/2020 at 2:24 PM, a Policy titled Administering Medications provided by the Nurse Consultant documented, .Policy Statement: Medications are administered in a safe and timely manner, and as prescribed . Staff follows established facility infection control procedures (e.g., handwashing .) for the administration of medications, as applicable.

F 0925 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Many	**Make sure there is a pest control program to prevent/deal with mice, insects, or other pests.**

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F 0925 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Many	(continued... from page 2) Based on observation and interview, the facility failed to ensure the kitchen was free of visible insects to prevent the potential for contamination in 1 of 1 kitchen. The failed practice has the potential to affect 95 residents who receive meals from the kitchen. The findings are: On 03/09/2020 at 10:22 AM, the Dietary Manager wiped the inside of the ice machine in the kitchen with ungloved hands. As she wiped the crevice between the lid and the bin, a small light-colored insect dropped onto the ice. The Dietary Manager was asked, Did the insect come from the napkin? She replied, No, it had to have just fallen from somewhere. The crevice was filled with a buildup of blackish substance. (surveyor took a photo)