STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045351	A. BUILDING _____ B. WING _____	08/11/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CARE MANOR NURSING AND REHAB	**804 BURNETT DRIVE MOUNTAIN HOME, AR 72653**

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 0580 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Complaint # (AR 886) and Complaint# (AR 963) was substantiated, all or in part, with these findings: Based on observation, record review, and interview the facility failed to notify the physician to ensure the resident received immediate medical care after an injury and failed to notify the family in a timely manner to allow them to be involved with the treatment decision making process for 1 (Resident (R) #2) case mix resident who had an injury. This failed practice had the potential to effect 7 residents who had an injury according to the facility Roster Matrix. The findings are: Resident #2 had a [DIAGNOSES REDACTED]. The Quarterly Minimum Data Set (MDS) with an Assessment reference Date (ARD) of 7/18/2020 documented the resident scored 3 (0 - 7 indicates severely impaired) on a Brief Interview for Mental Status (BIMS). a. An Incidents report documented, .bump/struck incidents .Nurses description: Staff showed treatment nurse residents right index finger. Right finger was discolored purple on the under side of hand with light swelling noted. (Resident #2) ., 5/28/2020 7:00 AM . Progress notes completed by the DON dated. 5/30/2020 at 18:37 (6:37 PM) .APN (Advanced Practice Nurse) notified DON that she did not know about this happening on 5/28 (2020) . b. A Progress Note provided by the Director of Nursing (DON) on 8/6/2020 at 2:48 PM documented, Agencies/people notified, .daughter (name), . 5/31/2020 15:11 (3:11 PM) . c. The APN progress note dated 6/1/20 documented, .I was notified last night at 6 PM by (Licensed Practical Nurse (LPN) #1) that she (Resident #2) has bruising and swelling of her left index and third finger. The bruising was already turning yellow, so it had to be there at least 3 days possibly longer . d. On 8/6/2020 at 3:55 PM, the APN was asked when was she notified of resident's bruising and [MEDICAL CONDITION]? She stated, No one had contacted me prior to that initial documentation when I ordered the Xray . I am in the building 3-4 days a week at least 20 hours a week, and would have been available. e. On 8/7/2020 at 10:38 AM, LPN #2 was. asked, Did you contact the Physician/APN at the time that the injury was discovered? She Stated, No. LPN #2 was asked, Do you know if the APN was notified? She stated, I don't know if the APN was told or not. LPN #2 was asked, Did you contact the Family at the time? LPN #2 stated, No ma'am. LPN #2 was asked, Should the Physician/APN and family been notified when discovered, or as soon as possible? LPN #2 stated, Absolutely. LPN #2 was asked, Is it usual to contact the Physician/APN with changes of condition? LPN #2 stated, Yes. LPN #2 stated, The late entry was entered on 5/31/2020 at 15:34 (3:34 p.m.) and I put everything in on the 31st, I sent APN (name) a message from my phone at 9:11 AM that morning and contacted (R#2) daughter. f. On 8/7/2020 at 2:55 PM, LPN #3 was asked, When is the physician/APN notified after a change of condition? LPN #3 stated, Immediately. LPN #3 was asked, When should the family be notified of changes with the resident? LPN #3 stated, It depends, if emergent deal with that, the physician first, then the family. g. On 8/7/2020 at 3:20 PM, the Administrator was asked when should the physician and family be notified of a change of condition? He stated, They should be notified as soon as possible, after providing emergent care if needed. h. On 8/10/2020 at 9:45 AM, the DON was asked if the Physician or their representative should be contacted with a resident's change of condition as soon as possible? She stated, Yes. As soon as emergent treatment has been provided. The DON was asked, Should the family be contacted as soon as possible after the physician? She stated, Yes. After the physician, so the nurse can let the family know of the Physician's treatment choice.
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** Complaint# (AR 963) was substantiated, all or in part, with these findings: Based on observation, record review, and interview the facility failed to ensure showers were provided for 3 (Residents #1, #2 and #3) case mix residents who were dependent on the staff for showers / ADL care. This failed practice had the potential to effect 69 residents according to the Census provided by the Administrator on 8/6/2020. The findings are: Resident #2 had [DIAGNOSES REDACTED]. The Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 7/18/2020 documented the resident scored 3 (0 - 7 indicates severely impaired) on a Brief Interview for Mental Status (BIMS). a. The Care Plan with a review date of 7/12/2020 documented, .ADL (activities of daily living)- Bathing Monday/Thursday Date Initiated: 07/01/2020 ., BATHING/SHOWERING: The resident requires Extensive assistance by 1 staff with bathing/showering 2X (times) weekly and as necessary. Date Initiated: 10/27/2017 . b. On 8/6/2020 at 3:42 PM, a shower task documentation sheet provided by the Assistant Director of Nurses (ADON) documented, resident received a shower on 7/09/2020 checked, 7/13/2020 checked, 7/16/2020 checked and 7/27/2020 checked. Resident didn't receive her scheduled showers on 7/20/2020 and 7/23/2020 with a blank area and NA (not applicable) checked. No documentation of family notification of refusals for showers. c. On 8/11/2020 at 8:54 AM, Certified Nurses Assistant (CNA) # 3 stated if we are unable to get to their showers we check NA (Not applicable).
F 0684 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide appropriate treatment and care according to orders, resident's preferences and goals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Complaint# (AR 963) was substantiated, all or in part, with these findings: Based on observations, record review, and interviews, the facility failed to ensure weekly skin assessments were completed to identify problem areas for treatment and prevention for 2 (Resident #1 and #3) of 5 (Resident #1, #2, #3, #4 and #5) case mix residents who required preventative skin measures. This failed practice had the potential to affect 69 residents that resided in the facility according to the Census provided by the Administrator on 8/6/2020. The findings are: 1. Resident #1 had [DIAGNOSES REDACTED]. The Annual Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 5/1/2020 documented the resident scored 15 (13-15 indicates Cognitively Intact) on a Brief Interview for Mental Status (BIMS); and required extensive assistance with one-person assist for bathing, independent with supervision for bed mobility, ambulation, toilet use and personal hygiene and was always continent of bowel and bladder. a. The updated Care Plan documented, (Resident #1) has potential impairment to skin integrity r/t (related to) fragile skin .Avoid scratching and keep hands and body parts from excessive moisture. Keep fingernails short. .Educate resident/family/caregivers of causative factors and measures to prevent skin injury. .Encourage good nutrition and hydration in order to promote healthier skin. .Follow facility protocols for treatment of [REDACTED].Identify/document potential causative factors and eliminate/resolve where possible. .Keep skin clean and dry. Use lotion on dry skin. .Use caution during transfers and bed mobility to prevent striking arms, legs, and

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 0684 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 1) hands against any sharp or hard surface. . b. On 8/7/2020 at 8:15 a.m., the record review of the NSG (Nursing) Weekly Assessments/Note with Skin audit Other was completed from 7/16/20 to 8/9/20. Assessments were completed on 7/16, 7/18, 7/25 and 8/1 and no assessment was found for the week of [DATE]- 8. 2. Resident #3 had the [DIAGNOSES REDACTED]. The Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 05/01/2020 documented the resident scored 09 (8-12 indicates moderately impaired in cognitive skills) on a Brief Interview for Mental Status (BIMS); and required limited assistance with one-person physical assist for bed mobility, independent with set up help only on transfer and with supervision and set up only for locomotion, dressing, eating, toilet use and personal hygiene, was always continent of bowel and bladder. a. The updated Care Plan documented, (Resident #3) has an ADL (Activities of Daily Living) self-care performance deficit r/t (related to) weakness, impaired mobility, ADL deficit .Avoid scrubbing & (and) pat dry sensitive skin . Report any changes to the nurse . b. On 08/10/2020 at 1:30 p.m., record review of the NSG (Nursing) Weekly Assessments/Note with Skin audit Other was completed from 06/30/20 to 8/10/20. Assessments were completed on 6/30, 7/7, 7/14, 7/21, 08/04 and 8/10 and no assessment was found for the week of June 7/26 - 8/1. 3. On 8/7/2020 at 8:50 a.m., the Director of Nursing (DON) was asked Are all of the weekly skin assessments in Point Click Care (PCC)? She stated, Yes. We QA'd (Quality Assessment an Assurance) the skin assessments. I asked for documentation showing that the weekly skin assessments were QA'd. 4. On 8/7/2020 at 9:14 a.m., the Administrator brought in a copy of the Quality Assurance Assessment (QAA) Action Plan, that documented, Newly identified Issue Weekly Skin Audit assessments are not up to date: Today's date: 7/15/2020 .GOAL OF THIS ACTION PLAN: Body Audits are to be completed on all residents in the building and be uploaded into PCC, in-service all nurses on the protocol for completing body audits and other UDA's according to the schedule set up in PCC . Complete body audits on each resident .Completed on 7/15/20 and 7/16/20, target date of completion 7/17/20. 5. On 8/7/20 at 9:00 a.m., the surveyor requested copies of Resident #1 and #3's weekly Nursing assessment. The DON stated, we QA the assessments because they were not being done. A copy of the QAA Action Plan was received from the Administrator at 9:14 am that documented, Newly Identified Issue: Weekly Skin Audit assessments are not up to date: Today's Date: 7/15/20 Note: GOAL OF THIS ACTION PLAN: Body Audits are to be completed on all residents in the building and be uploaded into PCC, in-service all nurses on the protocol for completing body audits and other UDA's according to the schedule set up in PCC. .Body Audits on 100 & 200 Hall, Complete body audits on each resident .Person Responsible: Treatment nurse/DON/ADON, Target Completion Date: 7/17/20: Completed on 7/16/20, 300 Hall completed on 7/15/20, 400 Hall completed on 7/16/20. 6. On 8/11/2020 at 10:54 a.m., the DON was asked, According to the skin assessment in PCC, in the week of 8/2 - 8/8, Resident #1's skin assessment was not completed. In the week of 7/26- 8/1, Resident #3's skin assessment was not completed. The DON stated, Because the nurses did not do them. The DON was asked, Who is responsible for ensuring the weekly skin assessments are completed? She stated, The hall nurses and the ADON and me are responsible for ensuring the nurses do them. The s asked, When skin assessments are not being completed weekly, could this affect their quality of care? She stated, No. I do not think so, Their skin is looked at during showers / care, I know there is a chance something might get missed. 7. On 8/11/2020 at 10:55 a.m., a requested Policy for skin Assessments was provided by the DON which documented, Prevention of Pressure Ulcers/Injuries. .The purpose of this procedure is to provide information regarding identification of pressure ulcer/injury risk factors and interventions for specific risk factors. .Assess the resident on admission .for exiting pressure ulcer/injury risk factors. Repeat the risk assessment weekly and upon changes in conditions, .
F 0865 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Have a plan that describes the process for conducting QAPI and QAA activities.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Complaint# (AR 963) was substantiated, all or in part, with these findings: Based on observation, record review, and interview the facility failed to monitor, track, and evaluate the effectiveness of their identified skin assessment concern for their Quality Assurance (QA) corrective action/performance improvement activities/plan for 2 (Resident #1 and #3) of 5 (Resident #1, #2, #3, #4 and #5) sample residents and failed ensure to ensure written data of their monitoring was collected to assess and revise the action plan as needed. This failed practice had the potential to affect 69 residents according to the Census provided by the Administrator on 8/6/2020. The findings are: 1. On 8/11/2020 at 10:29 a.m., Administrator was asked, What is the facility's QAA (Quality Assessment and Assurance) Process? He stated, We identify a problem. We develop a plan of action to correct it. Determine who will responsible for monitoring, revise the plan as needed, implement new interventions, until it has resolved. We document the finding, evaluate, depends on what it is. The monitoring may be daily, weekly or monthly. 2. Resident #1 had the [DIAGNOSES REDACTED]. The Annual Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 5/1/2020 documented the resident scored 15 (13-15 indicates Cognitively Intact) on a Brief Interview for Mental Status (BIMS); and required extensive assistance with one-person assist for bathing, independent with supervision for bed mobility, ambulation, toilet use and personal hygiene; and was always continent of bowel and bladder. a. On 8/7/2020 at 8:15 a.m., record review of the NSG (Nursing) Weekly Assessments/Note with Skin audit Other was completed from 7/16/20 to 8/9/20. Assessments were completed on 7/16, 7/18, 7/25 and 8/1 and no assessment was found for the week of [DATE]- 8. 3. Resident #3 had the [DIAGNOSES REDACTED]. The Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 05/01/2020 documented the resident scored 9 (8-12 indicates moderately impaired) on a Brief Interview for Mental Status (BIMS); and required limited assistance with one-person physical assist for bed mobility, independent with set up help only on transfer and with supervision and set up only for locomotion, dressing, eating, toilet use and personal hygiene; and was always continent of bowel and bladder. a. On 8/10/2020 at 1:30p.m., record review of the NSG (Nursing) Weekly Assessments/Note with Skin audit Other was completed from 06/30/20 to 8/10/20. Assessments were completed on 6/30, 7/7, 7/14, 7/21, 08/04 and 8/10 and no assessment was found for the week of June 7/26 - 8/1. 4. On 8/7/20/2020 at 8:50 a.m., the Director of Nursing (DON) was asked, Are all of the weekly skin assessments in Point Click Care (PCC)? She stated, Yes. We QA'd (Quality Assessment an Assurance) the skin assessments. I asked for documentation showing that the weekly skin assessments were QA'd. 5. On 8/7/20/2020 at 9:00 a.m., the surveyor requested copies of Resident #1 and #3's weekly Nursing assessment. The DON stated, We QA the assessments because they were not being done. 6. On 8/7/ 0 at 9:14 a.m., the Administrator, brought in a copy of the Quality Assurance Assessment (QAA) Action Plan, that documented, Newly identified Issue Weekly Skin Audit assessments are not up to date: Today's date: 7/15/2020 .GOAL OF THIS ACTION PLAN: Body Audits are to be completed on all residents I the building and be uploaded into PCC, in-service all nurses on the protocol for completing body audits and other UDA's according to the schedule set up in PCC . Complete body audits on each resident .Completed on 7/15/20 and 7/16/20, target date of completion 7/17/20. 7. On 8/11/2020 at 10:54 a.m., the DON was asked, Why did you QA the skin assessments? She stated, It's because the assessments were not getting completed weekly. The DON was asked, What was your plan of action? She stated, To in-service the nurses and from 7/15 to 7/17 to have all the skin assessments completed on all the residents then weekly as scheduled. The DON was asked, How are you tracking / monitoring the skin assessments? She stated, There is a calendar at the nurses' desk that informs the day and evening nurses by room and hall the skin assessment needed to be completed. I use that calendar to track the skin assessments weekly for completion and the plan is to monitor the weekly skin assessments for 3 months. The DON was asked, Do you have any documentation of the tracking or monitoring the skin assessments? She stated, No. I do not. To tell the truth I have not had a chance to see if they are being completed as scheduled. The DON was asked, According to the skin assessment in PCC, in the week of 8/2 - 8/8, Resident #1's skin assessment was not completed. In the week of 7/26- 8/1, Resident #3's skin assessment was not completed, why? The DON stated, Because the nurses did not do them. The DON was asked, Who is responsible for ensuring the weekly skin assessments are completed? She stated, The hall nurses and the Assistant Director Nurses (ADON) and me are responsible for ensuring the nurses do them. The DON was asked, When skin assessments are not being completed weekly, could this affect their quality of care? She stated, No. I do not think so. Their skin is looked at during showers / care. I know there is a chance something might get missed. The DON was asked, In the QAA Action Plan, it documented the nurses will be in-served, can I get a copy of that? She stated, Yes. 8. On 8/11/2020 at 10:11 a.m., a copy of the Quality Assessment and Assurance Committee Policy was received from the Administrator and documented, It is the policy of the facility to maintain a Quality Assessment and Assurance Committee to identify quality issues, and develop and implement appropriate plans of action to correct identified quality deficiencies within the facility through an interdisciplinary approach .The Committee will develop plans of action to correct identified quality issues, including monitoring the effect of implemented changes and revising the plans as needed . 8. On 8/11/2020 at 10:20 a.m., a copy of the in-service documented, Nurses: We have a new treatment nurse .She has been working on our skin issues and wounds throughout the building. .Now- skin audits are a part of each shift and as such should not be coming up late. Each of you need to do them in a timely manner. . (DON name, title). The in-service had no date or signature page, the 2nd page was a calendar for the Weekly Assessments. When the surveyor asked about the date and signature page, she stated, The

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F 0865 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 2) in-service was done verbally.
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 employees were screened prior to clocking in for their scheduled shift to prevent the potential for the spread of infection during a COVID-19 Pandemic and failed to ensure staff hands were sanitized after providing care for and between residents and after handling a trash waste bag to prevent the potential for the spread of infection during a COVID-19 Pandemic. This failed practice had the potential to effect 69 residents who resided in the facility according to the Resident Censes and Condition of Residents form provided by the Administrator on 8/6/2020. The findings are: 1. On 08/06/2020 at 12:30 PM, during the lunch meal observation, Certified Nursing Assistant (CNA) #2 opened the food cart and removed a lunch tray without sanitizing her hands. CNA #2 then took the tray into Resident room [ROOM NUMBER]A, set up the tray and returned to the food cart. CNA#2 removed tray #2 and took it to Resident Room # 408 and set the tray up the resident. CNA#2 exited the room without sanitizing her hands and proceeded to remove tray #3. On 8/6/2020 at 12:55 PM, CNA #2 was asked how long have you worked here? CNA #2 stated, About 7 months. CNA #2 was asked, How often are you to sanitize your hands? CNA #2 stated, After each resident we can use ABHR (alcohol-based hand rub) and then wash with soap and water after every 3 residents. CNA #2 was asked, Is that what you just did? CNA #2 stated No. 2. On 8/6/2020 at 1:10 PM, CNA #1 left Resident room [ROOM NUMBER] with a bag of trash, went into another room, exited without the trash bag, pulled an empty trash bag from the bottom of the trash receptacle affixed it to the receptacle then exited the resident's room. CNA #1 walked down the hall to Resident room [ROOM NUMBER] without sanitizing his hands. CNA #1 took the resident to the dining room. CNA#1 then returned to 400 Hall where he went into Resident Room # 403. CNA #1 was asked how long he had been employed? CNA #1 stated, He had worked in this facility for 2-3 months. CNA #1 was asked, Should you sanitize your hands between residents? CNA #1 Yes. CNA #1 was asked, When should you wash your hands? CNA #1 stated, When going in or out of a resident's room, after transferring and between residents. 3. On 8/7/2020 at 8:39 AM the DON provided a .QAA (Quality Assessment and Assurance) Action Plan . with had an initiation date of .03/30/2020 . that documented .all facility staff and essential providers will be screened before entering facility and have their temperature taken. Anyone who cannot pass the screener will not be allowed to enter . a. On 8/7/2020 at 1:55 p.m., Certified Nursing Assistant (CNA) walked through the back side of the nurses' station into the employee breakroom. Less than a minute later, he came out, went to the desk and had his temperature taken and filled out the questionnaire. b. On 8/7/2020 at 1:57 p.m., CNA #1 was asked if he was screened before going into the breakroom? CNA #1 stated, No. I went to clock in. CNA #1 was asked, Have you been instructed to clock in before being screened? CNA #1 stated. I haven't been told to clock in first. CNA #1 was asked, Why did you bypass the screening and go clock in? CNA #1 stated, I don't know. I just forgot. I came in through the back door. CNA #1 was asked, Are you allowed to come in through the back door? CNA #1 stated, We have to park back there. c. On 8/7/2020 at 2:00 PM, the House Keeping Supervisor was asked why the CNA was allowed to clock in before being screened? She stated, I didn't see them. I was screening someone else. She was asked, You couldn't have stopped them to have them wait? She stated, He came in through the back door. She was asked, He came all the way through the facility? She stated, We have to park back there. She was asked, Is there someone screening at the back door? She stated, No. Since the lock down, we've been coming through the back door. d. On 8/7/2020 at 2:59 PM, the Administrator provided an in-service document that stated .all staff have to enter building through the front door and be screened before going anywhere else in the building. Staff may not enter, at start of shift, any other doors to building. Screening must be completed before clocking in . signed with 12 employee signatures at the time the in-service was initiated. e. On 8/10/2020, the distance from the outer door being used by the staff coming in from the back door was stepped off and was approximately 123 feet to the break room door to the screening area. f. On 8/10/2020 at 8:00 AM, the Administrator stated he in-serviced all of the employees and let them know that they had to come in through the front entry. The back entry door has been locked from the outside, with no outside entry. 4. A form titled Handwashing/Hand Hygiene provided by the DON on 8/11/2020 at 10:55 a.m. documented, .all personnel shall follow the handwashing/hand hygiene procedures to help prevent the spread of infections to other personnel residents, and visitors ., use an alcohol -based hand rub containing at least 62% alcohol; or, alternatively, soap (antimicrobial or non-antimicrobial) and water for the following situations: ., before and after direct contact with residents; ., after contact with objects ., before and after eating or handling food ., before and after assisting a resident with meals; .