STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045452	A. BUILDING _____ B. WING _____	07/21/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
LAWRENCE HALL HEALTH & REHABILITATION	1051 WEST FREE STREET WALNUT RIDGE, AR 72476

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 0550 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the facility failed to ensure staff avoided placing signs that included residents' care information regarding personal care needs, in areas where they could be seen by other residents or visitors, to promote dignity for 3 (Residents #32, #12 and #36) of 3 sampled residents and failed to ensure staff assisted a resident to the toilet to promote dignity for 1 (Resident #119) of 26 (Residents #85, 108, 32, 20, 34, 83, 63, 119, 12, 118, 120, 5, 67, 100, 31, 106, 36, 53, 113, 81, 107, 23, 71, 19, 56, and 29) sampled residents who required assistance with toileting. These failed practices had the potential to affect 14 residents with visible signs posted as documented on the list provided by the Administrator on 7/20/20 and 6 residents who required assistance with toileting on the 300-hall as provided by the Administrator on 7/20/20 at 3:55 p.m. The findings are: 1. Resident #36 had a [DIAGNOSES REDACTED]. The Quarterly Minimum Data Set (MDS) with an assessment reference date (ARD) of 5/6/2020 documented the resident was severely impaired in cognitive skills for daily decision making per a staff assessment for mental status (SAMS) was totally dependent on the assistance of two plus people for bed mobility, transfers, dressing, and toileting and was totally dependent on the assistance of one person for eating and personal hygiene, had a feeding tube with proportion of total calories through tube feeding of 51% or more and average fluid intake per tube feeding as 501cc/ (cubic centimeters) day or more. a. The Care Plan dated 5/6/20, documented Receives PEG (Percutaneous Endoscopic Gastrostomy) tube feedings . HOB (head of bed) up 30 degrees at all times, attempt oral care every am, after meals, and at bedtime . NPO (nothing by mouth) sole source nutrition via tube . b. The Physician orders [REDACTED]. c. On 7/14/20 at 10:20 a.m., there were four signs posted above the head of the bed on the wall: two signs documented aspiration precautions with signs of aspiration one had a big red stop sign on it, one was hand written with feeding instructions when feeding present food then prompt to open mouth wide, and one with swallowing tips 1. Sit up in bed at 90 degrees angle during meal and 30 minutes after. Remain 45 degrees at all times a. supplement nutrition via PEG 2. Alternate small sips/bites 3. Make sure oral cavity is clear upon completion of meal and perform oral care. Oral care includes inside and outside of mouth, mouth is clean/lips are properly hydrated. d. On 7/17/20 at 11:33 a.m., the Social Service Director was asked, if having signs identifying a medical condition on the wall above the bed was a dignity issue? She replied, It could be an issue. e. On 7/20/20 12:50 p.m., the Director of Nursing was asked should signs be above Resident #36's bed? She replied, His mother place's them up there. She was asked, Are you aware the care plan documented he is NPO and solely fed by tube feeding? She stated, He's had some changes. I'll make sure it's updated correctly; he receives a pleasure tray. 2. Resident #12 had [DIAGNOSES REDACTED]. The Quarterly MDS with an ARD of 07/09/20 documents the resident scored 9 (8-12 indicates moderately impaired) on the Brief Interview for Mental Status (BIMS). The resident is a 2 plus persons physical assist with bed mobility, transfers, bathing and toilet use and requires a one-person physical assist with personal hygiene. a. On 07/13/20 at 01:44 p.m., the resident was lying in bed with eyes open and a sign posted at the head of the bed stated, Nursing Staff, Please place splint on right hand when (Resident #12) is in bed, Look for signs of redness/pain, Let OT (occupational therapy) know if splint ever causes issues . b. On 07/16/20 at 8:30 a.m., the Resident's Rights and Responsibilities received by the Administrator documented, .9. Treated with consideration, respect, and full recognition of his/her dignity and individuality including privacy in treatment and care for personal needs . 3. Resident #32 had [DIAGNOSES REDACTED]. The MDS with an ARD of 5/1/20 documented the resident scored 15 (13-15 indicates cognitively intact BIMS. The resident was a one-person physical assist with bed mobility, transfers, dressing, toilet use and bathing. a. On 07/13/20 at 12:44 a.m., the resident was sitting in a wheelchair brushing her dentures at a sink. The resident had 2 signs at the head of bed with one stating, Head of Bed is to be at 90 degrees when eating, drinking, or taking med (medication). b. On 07/14/20 at 9:12 a.m., the resident was sitting in a wheelchair in her room. The sign about health care remained above the bed. c. On 07/20/20 4:26 PM, an interview was conducted with the DON as follows: Should residents have signs at the head of bed indicating medical care and treatment? She stated, No, but if the family wants it, we try to respect that. 4. Resident #119 had [DIAGNOSES REDACTED]. The Significant Change MDS with an ARD of 6/30/2020 documented the resident was severely impaired in cognitive skills for daily decision making per the SAMS and was totally dependent on staff for with bed mobility, transfers, toilet use and bathing. a. On 7/14/20 at 9:32 a.m., Resident #119 was sitting in the geri-chair outside her room in the hallway. Resident #119 began yelling out, stated, I got to go pee. Licensed Practical Nurse (LPN) #1 walked up to the resident and asked Resident #119 if she had to pee. Resident #119 stated, Yes. LPN #1 stated, You got a brief on if you pee, they will come change you. Resident #119 again stated, I got to go pee. LPN #1 stated, Go ahead. b. On 7/16/20 at 9:40 a.m., Certified Nursing Assistant (CNA #3) was asked if she cared for this resident and stated, The resident's ability to communicate has declined in the last several months. She can say that she needs to pee but most of the time when she says it she won't go when she is placed on the toilet or that most of the time she has already went in her brief when she says that she needs to pee. c. On 7/16/20 at 2:30 p.m., the Director of Nursing (DON) was asked if Resident #119 had the ability to state that she needed to go pee? The DON stated, Yes, but most of the time she had already gone in her brief when she makes those statements. She was asked about LPN#1's statement to the resident about the brief. The DON stated, It was not appropriate for any member of the staff to tell the resident to go ahead and pee, they had a brief on. The DON was asked if it was a standard of practice in the facility? The DON stated, No it is not.
F 0558 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Reasonably accommodate the needs and preferences of each resident.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to ensure resident call lights were in place and readily available for residents to call for help when assistance was needed for 2 (Resident #19, and #83) 42 (Residents #85, 123, 108, 124, 57, 172, 32, 20, 34, 83, 63, 119, 47, 173, 94, 12, 118, 120, 122, 5, 67, 100, 31, 102, 27, 115, 36, 95, 53, 18, 69, 113, 81, 107, 25, 71, 19, 56, 33, 29, 44 and 2). This failed practice had the potential to affect 123 residents according to the Resident Census and Condition of Resident form dated 7/13/2020. The findings are: 1. Resident #83 had [DIAGNOSES REDACTED]. The Quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 5/29/2020, documented the resident scored 9 (8-12 indicates moderately impaired) on the Brief Interview for Mental Status (BIMS), required extensive assist of 2 persons for bed mobility, transfer, and toilet use, and required extensive assist of 1 person for dressing, and personal hygiene, and was frequently incontinent of bowel and bladder, and had 1, unstageable, deep tissue, pressure ulcer. a. The care plan dated 6/1/20 documented, .Potential for falls r/t (related to) history of falls, weakness . Place call light within reach and encourage use . b. On 7/14/2020 at 09:35 AM, Resident #83 was sitting in a wheelchair in his room. The call light was approximately 5 feet out of reach of the resident, draped across the bed

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 0558 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 1) post. (Photo taken at this time). Resident #83 was asked, Can you reach your call light? Resident #83 replied, Not that one over there, as he looked over his right shoulder at the call light draped across the bed post. 2. Resident #19 had [DIAGNOSES REDACTED]. The Quarterly MDS with an Assessment Reference Date of 4/23/2020, documented the resident scored 9 (8-12 indicates moderately impaired) on the BIMS, required extensive assist of 2 persons for bed mobility, transfer, dressing, toilet use, and was totally dependent on 1 person for eating, and personal hygiene, and was frequently incontinent of bowel and bladder. a. On 7/13/2020 at 02:11 PM., Resident #19 was sitting in a wheelchair the room. Resident #19's call light was behind the bedside table, clipped and draped around the bed rail and is approximately 5 feet out of the reach of the resident. Photo taken at this time. b. On 07/21/20 at 10:09 AM, the Director of Nursing (DON) was asked, Should call lights be in reach of the residents? The DON replied, Yes. c. On 7/21/20 at 10:20 AM, the Administrator was asked, Should call lights be in reach of the residents? The Administrator replied, Yes. d. A policy on Answering Call Lights, received from the on DON on 7/20/20 documented, .it is the policy of . to respond quickly to the requests and needs of our residents .
F 0578 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure documentation of the provision of written information regarding the right to formulate an advanced directive was readily available for review in the clinical record, to protect resident rights for 7 (Residents #32, 85, 83, 29, 63, 81, and 19,) of 26 (Residents #85, 108, 32, 20, 34, 83, 63, 119, 12, 118, 120, 5, 67, 100, 31, 106, 36, 53, 113, 81, 107, 23, 71, 19, 56, and 29) sampled residents whose clinical records were reviewed for advanced directive information. This failed practice had the potential to affect 52 residents who did not have advance directives, as documented on a list provided by the by the Administrator on 7/20/20 at 3:55 p.m. The findings are: 1. Resident #19 had a [DIAGNOSES REDACTED]. a. On 07/14/20 at 3:02 p.m., record review of Resident #19's hard chart and electronic health record, had no advance directive on file. b. On 07/14/20 at 2:12 p.m., Licensed Practical Nurse (LPN) #6 was asked, Where are the Advance Directives kept? LPN #6 replied, At the nurse's station and in their charts and in the Disaster Bags. Resident #19's Disaster Bag was reviewed with contents of a picture of Resident #19, a face sheet, and physician orders. There was no Advance Directive in the Disaster Bag. 2. Resident #63 had [DIAGNOSES REDACTED]. On 7/14/2020 at 2:50 p.m., record review of Resident #63 hard chart and electronic health record, had no advance directive on file. 3. Resident #83 had [DIAGNOSES REDACTED]. On 7/14/20 at 2:53 p.m., record review of Resident # 83 hard chart and the electronic health record, there was no advance directive on file. 4. Resident #85 had [DIAGNOSES REDACTED]. a. On 7/15/20 at 8:26 a.m., no advance directives were in the clinical record; a full code sheet was in the clinical record. b. On 7/16/20 at 8:26 a.m., the advance directive form was provided by the Administrator. 5. Resident #81 had [DIAGNOSES REDACTED]. a. On 7/15/20 at 10:39 a.m., no advance directives were in the clinical record. A Do Not Resuscitate (DNR) dated 2/28/17 was in the clinical record. b. On 7/16/20 at 8:35 a.m., the Administrator was asked for Resident #81 advance directives. At 8:43 a.m. the advance directive form was provided by the Administrator. 6. Resident #29 had [DIAGNOSES REDACTED]. a. On 07/15/20 at 10:50 a.m., no advance directives were in the clinical record, an DNR dated 8/8/14 was in the clinical record. b. On 7/16/20 at 8:35 a.m., the Administrator was asked for Resident #29's advance directives. At 8:43 a.m., the advance directive form was provided by the Administrator. c. On 7/16/2020 at 8:43 a.m., the Administrator was asked, Where were the advance directives located? She stated, They were in their chart. The Surveyor replied, The advance directives were not in the chart yesterday. She stated, We're working on our plan of correction now, and have conducted an audit. 7. Resident #19 had a [DIAGNOSES REDACTED]. a. On 07/14/20 at 3:02 p.m., record review of Resident #19's hard chart and electronic health record, had no advance directive on file. b. On 07/14/20 at 2:12 p.m., Licensed Practical Nurse (LPN) #6 was asked, Where are the Advance Directives kept? LPN #6 replied, At the nurse's station and in their charts and in the Disaster Bags. Resident #19's Disaster Bag was reviewed with contents of a picture of Resident #19, a face sheet, and physician orders. There was no Advance Directive in the Disaster Bag. 8. Resident #63 had [DIAGNOSES REDACTED]. On 7/14/2020 at 2:50 p.m., record review of Resident #63 hard chart and electronic health record, had no advance directive on file. 9. Resident #83 had [DIAGNOSES REDACTED]. On 7/14/20 at 2:53 p.m., record review of Resident # 83 hard chart and the electronic health record, there was no advance directive on file. 10. Resident #32 had [DIAGNOSES REDACTED]. a. On 7/15/20 at 10:21 a.m., record review was conducted of Resident 32's medical record. The resident's medical record did not contain an Advance Directive in the hard chart or the electronic health record. b. On 7/15/20 at 10:34 a.m., the Administrator was asked for Resident 32's Advanced Directive. At 11:14 a.m., the Administrator provided a copy of the Advanced Care Plan with a signature date of 4/13/19 and was asked where was the Advanced Care Plan? She stated, I don't want to tell you. c. On 07/21/20 at 08:22 a.m., the DON was asked, Should the medical record-hard chart or electronic health record contain the Advanced Directive? She stated, Yes.
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** Based on record review and interview, the facility failed to ensure the physician was immediately consulted for a change in resident condition to promote resident wellbeing and consistent continuity of care for 3 (Residents #123, #67 and #83) of 4 (Residents #123, #67, #119 and #83) residents who had a change in condition. This failed practice had the potential to affect 11 residents who had a change of condition in the last 120 days, as documented on the list provided by the Administrator on [DATE] at 9:56 AM. The findings are: 1. Resident #123 had [DIAGNOSES REDACTED]. The Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of [DATE] documented the resident scored 6 (,[DATE] indicated severely impaired) on the Brief Interview for Mental Status (BIMS). The resident required limited assistance of 1 staff member with activities of daily living. a. A Nurses Notes dated [DATE] documented at 1520 (3:20 p.m.), a Certified Nursing Assistant (CNA) informed the hall nurse that resident was complaining of chest pain. Vitals obtained as follows: Temperature 97.3, Heart Rate 61, Respiration 19, and Blood Pressure ,[DATE]. Skin warm, dry and pink. Resident did not voice a desire to go to the emergency room (ER). b. A Progress Notes dated [DATE] documented at 1554 (3:54 p.m.) CNA observed resident sitting in hallway, slumped in chair, skin cool and gray. Unresponsive to voice and touch. Hall nurse performing sternal rubs to awaken resident . Loaded on to stretcher as resident was a Full Code status. c. Nurse's note dated [DATE] at 1600 (4:00 p.m.) attempted to notify Adult Protective Services (APS) unsuccessful, left message to call back. d. Nurse's note dated [DATE] at 1610 (4:10 p.m.) the ER called requesting someone come sit with the resident as she was attempting to pull IV out and trying to get out of bed. Hospitality sent to assist resident in the ER. e. Nurse's note dated [DATE] at 1712 (5:12 p.m.) ER Registered Nurse (RN) notified hall nurse that resident had expired. f. On [DATE] at 12:55 p.m., the Director of Nursing (DON) was asked, If a resident has a new complaint of chest pain what should the nurse do? The DON stated, Check the orders see if they have any Nitro ([MEDICATION NAME]) ordered, send to ER and call the doctor. g. On [DATE] at 01:56 PM, the DON stated, I could not find any documentation that the physician was notified of the chest pain, I also could not locate a transfer order or a transfer sheet that we normally do. I guess they just shipped her. 2. Resident #67 had [DIAGNOSES REDACTED]. The Quarterly MDS documented the resident scored 15 (,[DATE] indicates cognitively intact) on the BIMS, required extensive assist of 2 persons for bed mobility, transfer, toilet use, and required extensive assist of 1 person for dressing, and personal hygiene, supervision for eating, and was always continent of bowel and had an indwelling catheter. a. A nurse's note dated [DATE] documented, .new order to replace current right knee brace for [DIAGNOSES REDACTED]. Noted and processed, removed knee brace from room and took to social to call appropriate company for fitting of knee brace . b. A Restorative note documented, .resident refused due to no knee brace . waiting on knee brace to come in . refused . can't walk without a brace . ambulation on hold till knee brace comes in .

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F 0580 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 2) with the following dates: [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE] . c. The Care Plan dated [DATE] documented, .Potential for falls related to unsteady gait, weakness, history of falls . transfers/ambulates with one staff assist and gait belt . d. A physician order with a start date of [DATE] documented, .Restorative upper pedal bike x (times) 10 minutes 3 x a week for 8 weeks. Stop date [DATE] . e. On [DATE] at 12:00 PM, record review of the APRN (Advance Practice Registered Nurse) Notification Book on the 400 Hall, dated [DATE] through [DATE], had no documentation of physician notification for a knee brace, to aid with ambulation and therapy for Resident #67. f. On [DATE] at 1:50 PM, Restorative Aide (RA) #1 was asked, When was Resident #67's knee brace ordered? RA #1 replied, I don't know, you'll have to talk to Social about that. RA #1 was asked, Has Resident #67 knee brace come in? RA #1 replied, No. RA #1 was asked, Did you notify anyone? RA #1 replied, You'll have to talk to Social, Social takes care of that. g. On [DATE] at 1:52 PM, Social Service (SS) was asked, When was Resident #67's knee brace ordered? SS replied, I sent an email to SCOPE (Orthotic and Prosthetic Services), in March, that we had a resident that needed a knee brace. SS was asked, Did they ever reply? SS replied, He didn't talk to me. SS was asked, Why hasn't the knee brace come in? SS replied, I don't know. SS was asked, Did you notify anyone? SS replied, I think I had talked with the Director of Nursing (DON). SS was asked, Has the physician been notified? SS replied, I just send the email to SCOPE. h. On [DATE] at 1:57 PM, the DON was asked, When was Resident #67's knee brace ordered? The DON replied, Apparently we are in a standstill because of COVID, they measured her, and they have not been able to order it. The DON was asked, Have you notified the physician? The DON replied, Probably not. i. As of [DATE] at 2:28 PM, the DON stated, There is no documentation for notifying the physician for Resident #67 knee brace. j. On [DATE] at 10:09 AM, the DON was asked, Should the physician be notified of a resident's change of condition? The DON replied, Yes. The DON was asked, Should restorative orders be followed? The DON replied, Yes. k. A policy on Restorative Services received from the Administrator on [DATE] documented, It is the policy . to assist in maintaining the current Level of Care of each resident . 3. Resident #83 had [DIAGNOSES REDACTED]. The Quarterly MDS, with an ARD of [DATE], documented the resident scored 9 (,[DATE] indicates moderately impaired) on the BIMS, required extensive assist of 2 persons for bed mobility, transfer, and toilet use, and required extensive assist of 1 person for dressing, and personal hygiene, and was frequently incontinent of bowel and bladder, and had 1, unstageable, deep tissue, pressure ulcer. a. A care plan dated [DATE] documented, .at risk for skin breakdown related to incontinence, cognition, impaired mobility, and admitted with stage 2 on left heel . Foam boot on Left foot . b. On [DATE] at 11:27 AM, and [DATE] at 9:35 AM, Resident #83 was sitting in a wheelchair in his room. There were heel protectors on both heels. The resident had a dark, black area to the second digit on the left foot and a dark, black area to the second digit on the right foot. These two digits had no dressing or cover. There is no physician order for [REDACTED].#83 was sitting on the edge of the bed. Resident #83 has no heel protectors on his feet. A dark, red, and crusted area was noted to the second digit on the right foot and a dark, black area noted to the second digit on the left foot was uncovered and with no dressing. Resident #83 was asked, Are they putting anything on your toes? Resident # 83 replied, No. Resident #83 was asked, Are you supposed to be wearing boots on your feet? Resident #83 replied, I don't know. d. On [DATE] at 09:50 AM, Certified Nursing Assistant (CNA) #4 was asked, Is Resident #83 supposed to have heel protectors on? CNA #4 replied, I'd have to ask the wound treatment nurse. CNA #4 was asked, Do you know what that is on Resident #83 toe? CNA #4 replied, Looks like a scab. e. On [DATE] at 10:37 AM, Registered Nurse (RN) #1 was asked, Is Resident #83 supposed to be wearing heel protectors to both feet? RN #1 replied, Yes. RN #1 was asked, Does Resident #83 have treatment orders for the second digit on the left and right foot? RN #1 replied, I put barrier cream as needed, I don't have that as a treatment on the Medication Administration Record [REDACTED]? RN #1 replied, No, normally he has a boot on. RN #1 was asked, Do you call the doctor with changes? RN #1 replied, Normally a nurse practitioner comes for rounds, we put a note on the report sheet. f. On [DATE] at 12:00 PM, record review of the 400 Hall APRN Notification Book, dated [DATE], through [DATE] had no documentation of the physician being notified of Resident #83 wounds to the second digits on the right and left foot. g. On [DATE] at 01:52 PM, RN #1 was asked, Did you notify the physician about Resident #83 wounds on toes. RN #1 replied, No. RN #1 was asked, Has the Physician/APRN been notified of Resident #83 wounds on his toes? RN #1 replied, No. h. A policy titled, Wound Care Protocol provided by the DON on [DATE] documented, It is the policy of . that staff follow a consistent wound care protocol . to provide optimum skin care . Obtain Physician order . wound assessments done weekly until wound is healed .
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 and interview, the facility failed to ensure 2 linen cart covers on the 100, 200, and 300 were in good repair, the plastic molding was free of sharp edges on room [ROOM NUMBER], the bottom corner of the 300 hall nurses station was free of sharp edges, and wheelchair cushions were in good in repair, and clean linens were provided when dirty to promote a home. This failed practice had the potential to affect all 123 residents according to the Resident Census and Condition of Resident form dated 7/13/20. The findings are: 1. Resident #118 had [DIAGNOSES REDACTED]. The Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 6/29/20 documented the resident scored 15 (13-15 indicates cognitively intact) on the Brief Interview for Mental Status (BIMS). The resident requires extensive assistance with bed mobility, dressing, toilet use and personal hygiene. On 07/14/20 at 10:55 AM, the resident was lying in bed with eyes open. There were white linens draped over the resident that contained brown and black substances at the resident's feet. 2. Resident #20 had [DIAGNOSES REDACTED]. The MDS with an ARD of 4/20/20 documented the resident was severely impaired for cognitive skills for daily decision making, required extensive assistance of one person for transfers, and is at risk of developing pressure ulcers/injuries. a. The plan of care dated 6/30/20 documented, .Patient at risk for skin issues . b. On 07/13/20 at 11:43 AM, Resident #20 was sitting in a Broda chair in her room. The Broda chair's seat cushion was ripped with the foam exposed. The surveyor took a photo at this time. c. On 07/16/20 at 3:31 PM, the Director of Nursing (DON) was asked, Should a resident's wheelchair cushion be ripped and frayed at the seams? She stated, No The DON reported that the Certified Nursing Assistants (CNAs) or the nurses should report these findings so the resident could receive a new cushion. She agreed that the ripped seat cushion could cause a skin tear. 3. On 7/13/20 at 12:32 PM, the seat of a Blue chair on the 400 Hall was ripped and torn approximately 1 foot in length with foam stuffing exposed. A photo was taken at this time. a. On 7/13/20 at 01:33 PM, a Linen Cart cover on the 200 Hall was ripped, frayed, and torn. A photo was taken at this time. b. On 07/13/20 at 01:34 PM, a Linen Cart cover on the 300 Hall was ripped, frayed, and torn. A photo was taken at this time. c. On 07/13/20 at 01:37 PM, a Linen Cart cover on the 300 Hall near room [ROOM NUMBER] was ripped and frayed. A photo was taken at this time. d. On 07/14/20 at 09:16 AM, a blue Linen Cart cover on the 100 Hall was frayed and ripped. A light green Linen Cart cover on the 100 Hall was frayed, ripped, and torn. A photo was taken at this time. e. On 07/21/20 at 10:09 AM, the DON was asked, Should the torn, ripped, and frayed linen cart covers, be in the facility? The DON replied, No. The DON was asked, Should the blue chair be ripped and torn with foam stuffing exposed? The DON replied, No. f. On 07/21/20 at 10:20 AM, the Administrator was asked, Should the torn, ripped, and frayed linen cart covers be in the facility? The Administrator replied, No.
F 0604 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to ensure a physician order [REDACTED]. The findings are: Resident #19 had [DIAGNOSES REDACTED]. The Quarterly Minimum Data Set (MDS) with an Assessment Reference Date of 4/23/2020, documented the resident scored 9 (8-12 indicates moderately impaired) on the Brief Interview for Mental Status (BIMS), required extensive assist of 2 persons for bed mobility, transfer, dressing, and toilet use and had no documented restraints. a. The Care Plan dated 6/19/20 documented, .Potential for injury and complications related to [MEDICAL CONDITION] Disorder . Self-releasing harness to be worn when out of bed . Potential for fall related to disease

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	045452	A. BUILDING _____ B. WING _____	07/21/2020

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F 0604 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 3) process and frequent jerking movements . Use self-releasing safety device when resident is in wheelchair for positioning and for safety . b. The July 2020 physician order [REDACTED]. c. On 07/13/2020 at 02:13 PM, 7/14/2020 at 9:12 AM and 10:05 AM, Resident #19 was sitting in a wheelchair in her room with a butterfly harness and seatbelt strapped around the resident's upper torso and waist. d. On 7/14/2020 at 2:07 PM, Resident #19 was in sitting in a wheelchair in her room with a butterfly harness and seatbelt strapped and around upper torso and waist. Licensed Practical Nurse (LPN) #6 was asked, Can Resident #19 release the butterfly harness? LPN #6 replied, No, she tries. LPN #6 was asked, Would that be considered a restraint? LPN #6 replied, That's what I thought too, but her family wanted it and it's care planned. e. On 7/15/2020 at 11:22 AM, the Director of Nursing (DON) was asked, Where are the restraint assessments located? The DON replied, There is no one on restraints. f. On 07/16/2020 at 11:00 AM, the DON was asked, Do you have a physician order [REDACTED]. The DON was asked, How long has Resident #19 had the butterfly harness? The DON replied, Since she admitted in 2009. The DON was asked, Why does Resident #19 have the butterfly harness? The DON replied, She has [MEDICAL CONDITION], and it's for precautions. The DON was asked, Who provides the monitoring, like when and how often the device is released? The DON replied, Take it off for bathing, and toileting, she takes it off all the time. The DON was asked, Has Resident #19 had any injuries with this device in place? The DON replied, No. The DON was asked, What other interventions have been attempted and evaluated to minimize/eliminate the use of butterfly harness? The DON replied, No other interventions since she has been here. g. On 7/16/2020 at 12:33 PM, the DON was asked, do you have a physician order [REDACTED]. The DON was asked, Do you have an assessment for Resident #19 Butterfly Harness? The DON replied, Just the assessment on the side rails, with the Butterfly harness added. The DON was asked, Do you have a family consent for the Butterfly Harness? The DON replied, No. h. On 7/17/2020 at 09:01 AM, Resident #19 was observed in wheelchair with Butterfly Harness and Seatbelt in place. Licensed Practical Nurse (LPN) #7 was asked, Can Resident # 19 release the Butterfly Harness and seatbelt? LPN #7 replied, No. LPN #7 was asked, Can you ask Resident #19 to undo/release her harness/seatbelt. LPN #7 asked Resident #19, Can you undo your belt. Resident #19 replied, No. All questions the LPN #7 asked Resident #19, were answered with a No. Resident #19 did not attempt to release the Butterfly Harness. i. On 07/21/20 at 10:09 AM, the DON was asked, If a resident cannot release a Butterfly Harness, would that be considered a restraint? The DON replied, No. j. On 07/21/20 at 10:20 AM, the Administrator was asked, if a resident cannot release a Butterfly Harness, would that be considered a restraint? The Administrator replied, I don't feel like it is considered a restraint.
F 0641 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**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 a comprehensive Minimum Data Set (MDS) assessment accurately reflected deterioration of the activities of daily living (ADL) status for 1 (Resident #106) of 1 sampled resident to facilitate the ability to plan and provide the necessary care for the resident. This failed practice only affected Resident #106. The findings are: Resident #106 had [DIAGNOSES REDACTED]. The 5-day MDS with an assessment reference date (ARD) of 3/5/2020 documented the resident required supervision and set up only for bed mobility, limited assistance of one person for eating and personal hygiene, and extensive assistance of one person for toilet use. a. The Quarterly MDS with ARD date of 6/11/2020 documented the resident required extensive assistance of one person for bed mobility, eating and personal hygiene and extensive assistance of two plus people for toilet use. The resident had a decline in 3 areas of ADL in a 3-month period. b. On 7/20/20 at 12:58 p.m., Licensed Practical Nurse (LPN) #2 was asked, What constitutes a Significant Change in Status Assessment? She stated, A decline or improvement in 2 or more areas. She was asked to compare the Quarterly MDS dated [DATE] to the 5-day MDS dated [DATE] and was asked if a significant change assessment was warranted? She stated, It should have been.
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 record review and interview, the facility failed to ensure a comprehensive care plan was developed to oxygen therapy to promote continuity of care for 1 (Resident #71) of 12 (Residents #71, 5, 96, 100, 120, 60, 66, 94, 83, 63, 67 and 113) sampled residents who used oxygen. This failed practice had the potential to affect 30 residents who used oxygen as documented on lists provided by the Administrator on 7/21/20. The findings are: Resident #71 has a [DIAGNOSES REDACTED]. The Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 6/4/20 documented the resident scored 8 (8-12) indicates moderately impaired) on the Brief Interview for Mental Status (BIMS). The resident required a one-person physical assist with bed mobility, transfer, dressing, toilet use, personal hygiene and receives oxygen therapy while a resident. a. On 07/13/20 at 1:40 PM, resident walked from the bathroom to her bed and sat on the bed with Certified Nursing Assistant (CNA) #1 standing with her. The resident's oxygen nasal cannula was lying draped over her bedside table. CNA #1 picked up the oxygen cannula and tubing from the bedside table and placed it on the resident's nose. The oxygen setting on the wall was set at 2 liters per minute. b. The Care Plan updated 6/16/20 had no documentation of oxygen therapy. c. The July 2020 Physician order [REDACTED].@ (at) 2-4 LPM (Liters Per Minute) via nasal cannula as needed to keep sat (oxygen saturation) > (greater than) 90% . d. On 07/20/20 at 4:26 PM, the Director of Nursing (DON) was asked, Should oxygen therapy be documented on the Care Plan? She stated, Yeah.
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 resident's facial hair/whiskers were shaved and fingernails were cleaned and trimmed to promote good personal hygiene and grooming for 5 (Residents #25, #83, #118, #107 and #119) of 18 (Residents #108, #107, #34, #53, #20, #2, #18, #100, #31, #95, #57, #5, #12, #25, #83, #119, #19, #118) sampled residents who were dependent for nail care and shaving. The failed practice had the potential to affect 16 residents who were dependent for nail care, and 21 residents who are shaved as documented on lists provided by the Administrator on 07/20/2020 at 3:55 PM and on 7/21/20 at 8:15 AM. The findings are: 1. Resident #119 had [DIAGNOSES REDACTED]. The Significant Change in Condition Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 6/30/2020 documented the resident was severely impaired in cognitive skills for daily decision making per a staff assessment for mental status, was totally dependent on staff for two plus staff with bed mobility, transfers, toilet use and personal hygiene and bathing. a. The July 2020 Treatment Administration Record documented, Nail Care every 2 weeks . b. On 7/14/20 at 9:31 AM, Resident #119 was sitting in her geri-chair. Her nails were untrimmed, and the nail polish was worn and grown out toward the tips on the nails. c. On 7/16/20 at 10:51 AM, Resident #119 was lying in bed. Her fingernails remained untrimmed, jagged and unkept. The resident's fingernails on both hands were long, and extended 1/4 inch past the tips of the fingers. d. On 7/16/20 at 1:54 PM, Certified Nursing Assistant (CNA) #3 was asked, Does the resident receive assistance with ADLs? (activities of daily living) CNA #3 stated, Yes. She was asked How much assistance does the resident need? CNA #3 stated, Extensive to total care required for all ADLs. e. On 07/16/20 at 2:15 PM, the Director of Nursing (DON) was asked when nail care was last performed on Resident #119. The DON stated, We are changing the time it is done now. It was scheduled at 6:00 am and they did not want to wake her up, so instead of changing the time or letting someone know I guess they just didn't do it. They were going to change the time of when her nail care was to be performed. 2. Resident #107 had [DIAGNOSES REDACTED]. The MDS with a ARD of 6/19/20 documented the resident was cognitively intact, and required extensive assistance of one person for personal hygiene. a. A physician's orders [REDACTED].clean, inspect, trim nails every 2 weeks . b. On 07/15/20 at 10:57 AM, the resident's fingernails on the right hand were approximately 1/2 inch in length past tip of fingers with a brown substance underneath. The resident was asked if he gets his nails trimmed. He stated, I just like them filed . He was asked if his nails where too long for what he liked. He stated, Yeah. c. On 07/16/20 at 3:31 PM, the DON was asked, Who is responsible for trimming /filing and /or cleaning a resident's fingernails? She stated, .CNAs unless Diabetic . She was asked, Should a resident's fingernails be approximately 1/2 in length with a brown substance under the nails? She stated, No . d. A facility Policy titled Nail Care provided by the DON on 7/16/20 documented, .provide cleanliness and prevent infections by assuring that proper nail care is done on each resident . Nail

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F 0677 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 4) care should be done as often as needed, but at least twice weekly . 3. Resident #25 had [DIAGNOSES REDACTED]. The Quarterly MDS with an ARD of 4/24/2020, documented the resident scored 15 (13-15 indicates cognitively intact) on the Brief Interview for Mental Status (BIMS), was totally dependent for transfer, and bathing, and required extensive assist of 1 person for personal hygiene, and was always incontinent of bowel and bladder. a. The Care Plan dated 1/20/20 documented, .Requires extensive assist with ADL's related to weakness and easily fatigues . Shaving-facial and body hair per resident preference . b. On 07/16/20 at 08:56 AM, Resident #25 stated, I'm having a hard time getting shaved, they told me I'm a Diabetic and I have to use an electric razor, but mine needs blades, because they are dull. Resident #25 had facial hair approximately a quarter of an inch in length. The resident was asked, Do you have an electric razor? Resident #25 replied, I have an electric razor, they say my family will have to replace it. Resident #25 was asked, when was the last time he was shaved. Resident #25 replied, This is about 3 weeks of beard. He was asked, Did they use an electric razor? Resident #25 replied, No, they shaved me with a regular razor. He was asked, Is your family aware you need new blades? Resident #25 replied, I don't know, they live away from here. c. On 07/16/20 at 09:32 AM, Registered Nurse (RN) #2 was asked, When is nail care and shaving performed? RN #2 replied, It will show up on the Medication Administration Record [REDACTED]. RN #2 was asked, Who is responsible for nail care? RN #2 replied, Nurses do Diabetic nail care. RN #2 was asked, What about shaving a diabetic? RN #2 replied, We have to use electric razors. RN #2 was asked, Who supplies that? RN #2 replied, The family usually buys that. RN #2 was asked, What if a resident need new blades? RN #2 replied, We contact Social Service and she gets a hold of the family? RN #2 was asked, What if you can't get a hold of the family? RN #2 replied, We keep trying, we usually try to keep blades for them, we tell the family to bring extras? RN #2 was asked, What if the family can't get out or has no money? RN #2 replied, The Social Service has one of our activity persons go and get some blades. d. On 07/16/20 at 11:00 AM, the DON was asked, Who's responsible for ensuring residents get shaved and nail care is performed? The DON replied, The CNAs do the care, and the Charge Nurse oversees, the Charge Nurse does Diabetic nail care. The DON was asked, How is a Diabetic resident shaved, and are they supposed to be shaved with an electric razor? The DON replied, If the family/resident provide an electric razor, they use it. The DON was asked, Is it your policy that a Diabetic resident only be shaved with an electric razor? The DON replied, No, it is not our policy. The DON was asked, If a resident needs blades for an electric razor, who takes care of that? The DON replied, If they have money, we go and get them, if not, we contact the family. The DON was asked, Does Resident #25 have money? The DON replied, No, we contacted the family, left a message, Social can't remember the date. e. On 7/16/20 at 11:19 AM, the Social Service was asked, Did you contact Resident #25's family (to let them know) that he needed blades for his electric razor? Social Service replied, It was yesterday, I called her and left messages about the blades and she is going to bring him one. 4. Resident #83 had a [DIAGNOSES REDACTED]. The MDS, with an Assessment Reference Date (ARD) of 5/29/2020, documented the resident scored 9 (8-12 indicates moderately impaired) on the Brief Interview for Mental Status (BIMS), required extensive assist of 2 persons for bed mobility, transfer, and toilet use, and required extensive assist of 1 person for dressing, and personal hygiene, and was frequently incontinent of bowel and bladder, and had 1, Unstageable, deep tissue, pressure ulcer. a. A Care Plan dated 3/2/20 documented, .Requires extensive assist with ADLs related to limited mobility, weakness, and confusion . Shaving-facial and body hair per resident preference . b. A Bathing Roster dated 7/16/2020 documented, Resident #83 received a bed bath on 7/9/2020, a shower on 7/5/2020 and a shower on 6/25/2020. c. On 07/14/2020 at 09:35 AM, Resident #83 had facial hair, approximately a quarter of an inch long. Resident #83 was asked, Do you have to have help to shave? Resident #83 replied, Yes, they usually do it for me. Resident #83 was asked, Do you like your whiskers being long? Resident #83 replied, No. d. On 07/14/2020 at 09:50 AM, CNA #5 was asked, When are the residents (women and men) shaved? CNA #5 replied, When they get a shower, twice a week, unless it's care planned for more times per week. CNA #5 was asked, Should women and men have whiskers and beards? CNA #5 replied, No. CNA #5 was asked, Would that be a dignity issue? CNA #5 replied, Yes. 5. Resident #118 has [DIAGNOSES REDACTED]. The Quarterly MDS with an ARD of 6/29/20 documented the resident scored 15 (13-15) indicates cognitively intact) on the BIMS. The resident requires extensive assistance with bed mobility, dressing, toilet use and personal hygiene. a. On 07/13/20 at 1:47 PM, the resident was lying in bed with approximately 1 inch of facial hair present. b. On 07/15/20 at 09:31 AM, the resident was lying in bed with approximately 1 inch of facial hair present and with a brown substance on the right and left side of the face in the corners of the mouth. c. On 7/15/20 at 9:35 AM, the resident was asked, Do you like the hair shaved on your face? She stated, Yes, I do but they haven't gotten around to do it. She was asked, Have you ever told the facility you would like the face hair off? She stated, Yes, I have told them . d. On 07/17/20 at 08:57 AM, the DON was asked, Do you have any documentation for June where she received a shaved? She stated, No because we updated the Care Plan. She was asked, What did you update it to? She stated, Shaving per preference.
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 pressure ulcer treatments were effective and promoted healing to prevent potential deterioration or infection of the pressure ulcer for 2 (Resident #119 and #83) of 2 sampled residents who had pressure ulcers; and failed to ensure skin audits were completed weekly to monitor skin conditions for 1 (Resident #83) of 2 (Resident #83 and #119) sampled residents who had pressure ulcers. These failed practices had the potential to affect 6 residents who had pressure ulcer as documented on a list provided by the Administrator on 7/20/20 at 3:55 PM. The findings are: 1. Resident #119 has [DIAGNOSES REDACTED]., transfers, toileting and bathing, had Moisture Associated Skin Damage, at risk for skin issues r/t (related to) immobility, falls, incontinence, diabetes, and weight loss. a. The Treatment Record dated 6/26/20 documented, Coccyx - apply barrier cream to open area on coccyx BID (two times daily) until healed. b. The Physicians orders dated 7/02/2020 documented, Coccyx - apply barrier cream to open areas on coccyx. c. On 07/16/20 at 09:18 AM, prior to the wound treatment, Registered Nurse (RN) #1 stated, the resident did not receive a dressing, that she only had to apply barrier to the area for protection. d. On 07/16/20 at 9:25 AM, RN #1 obtained a cream from the treatment cart, and placed some in a small plastic cup, she stated, The cream is very thick. RN #1 then obtained another cream from the cart and put this cream in the same cup as the first cream. The resident had 2 open areas on the inside of the buttocks and an open area at the coccyx. RN #1 stated, The open areas are measured weekly, and they used to apply a foam dressing to the area just for protection but on Monday (7/13/20) they stopped using the foam dressing because it looked good. We were applying barrier to protect the skin to prevent it from getting wet. She stated there has not been an actual treatment to the area. After the treatment, RN #1 stated, she was going to apply a dressing. She was asked why she was going to put on a dressing and stated, It looks a little more open looking. She obtained a (border foam) from the cart. RN #1 was asked, what the areas were classified as? And she stated, excoriation. She took her gloved finger and mixed the 2 creams in the cup and applied the cream to the open areas, using the same finger to both areas, and applied gauze to the area. e. On 7/16/20 at 02:16 PM, the Director of Nursing (DON), was asked about the status of the resident's pressure ulcers and stated, There are no measurements done on the wounds, we normally only measure pressure. The MD (Medical Doctor) has not seen the resident since May, and she did not have the area at that time. The resident should be seen this month. The DON was asked if she had seen the wound, and she stated, No. The DON was then shown the pictures of the wound and was asked if she would call the open areas to the buttocks and the coccyx excoriation? The DON stated, No. She was asked what she would call it or classify it as? The DON stated, I am not a doctor so I cannot diagnose. The area on the left buttock and coccyx probably should have been measured. f. The Wound Care Protocol obtained from RN #1 on 7/16/20 9:52 AM documented, 1. Obtain Physician order, .#21 Document wound assessment in nurses notes . #22 Wound assessment done weekly until wound is healed. Wound assessment will continue on pressure ulcers for 2 weeks post documented heal date . #23 Wound assessment to be reviewed/discussed by IDT (interdisciplinary team) weekly during wound care meeting. 2. Resident #83 had [DIAGNOSES REDACTED]. The Quarterly MDS, with an ARD of 5/29/2020, documented the resident scored 9 (8-12 indicates moderately impaired) on the BIMS, required extensive assist of 2 persons for bed mobility, transfer, and toilet use, and required extensive assist of 1 person for dressing, and personal hygiene, and was frequently incontinent of bowel and bladder, and had 1, unstageable, deep tissue, pressure ulcer. a. A care plan dated 6/1/20 documented, .at risk for skin breakdown related to incontinence, cognition, impaired mobility, and admitted with stage 2 on left heel . Foam

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F 0686 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 5) boot on Left foot . b. On 7/13/2020 at 11:27 AM, and 7/14/20 at 9:35 AM, Resident #83 was sitting in a wheelchair in his room. There were heel protectors on both heels. The resident had a dark, black area to the second digit on the left foot and a dark, black area to the second digit on the right foot. These two digits had no dressing or cover. There is no physician order for [REDACTED].#83 was sitting on the edge of the bed. Resident #83 has no heel protectors on his feet. The left heel is on the floor mat with a dressing to the left heel that is not intact. One heel protector is at the end of the bed. Another heel protector is on the floor, to the right of Resident # 83, and has a red dried substance on the outside. The inside of the heel protector is stained with brown and yellow substance. A dark, red, and crusted area was noted to the second digit on the right foot and a dark, black area noted to the second digit on the left foot was uncovered and with no dressing. Resident #83 was asked, Are they putting anything on your toes? Resident # 83 replied, No. Resident #83 was asked, Are you supposed to be wearing boots on your feet? Resident #83 replied, I don't know. d. On 7/17/20 at 09:50 AM, Certified Nursing Assistant (CNA) #4 was asked, Is Resident #83 supposed to have heel protectors on? CNA #4 replied, I'd have to ask the wound treatment nurse. CNA #4 was asked, What does the red area on the heel protector look like to you? CNA #4 replied, Blood. CNA #4 was asked, Should that be on it and on the floor? CNA #4 replied, No. CNA #4 was asked, Would that be an infection control issue? CNA #4 replied, Yes. CNA #4 was asked, Do you know what that is on Resident #83's toe? CNA #4 replied, Looks like a scab. CNA #4 was asked, Do you allow bandaged wound to be on the floor? CNA #4 replied, Not usually, they usually have socks on or these boots, but these boots need to be cleaned. e. On 7/17/20 at 10:37 AM, Registered Nurse (RN) #1 was asked, Is Resident #83 supposed to be wearing heel protectors to both feet? RN #1 replied, Yes. RN #1 was asked, Does Resident #83 have treatment orders for the second digit on the left and right foot? RN #1 replied, I put barrier cream as needed, I don't have that as a treatment on the Medication Administration Record [REDACTED]? RN #1 replied, No, normally he has a boot on. RN #1 was asked, Do you do skin assessments and where are they located? RN #1 replied, The nurses do them and I'd have to look for them. RN #1 was asked do you call the doctor with changes. RN #1 replied, Normally a nurse practitioner comes for rounds, we put a note on the report sheet. f. On 7/17/20 at 12:24 PM, the Director of Nursing (DON) was asked, Do you have skin audits for Resident #83? The DON replied, I do not, there are no skin audits The DON was asked, Who is responsible for residents' skin/body audits? The DON replied, The nurses are supposed to do them weekly. The DON was asked, Where would the skin/body audits be documented? The DON replied, In the computer. g. On 07/20/20 at 11:33 AM, the DON was asked for skin audits for seven residents. The DON replied, I don't think I have them, but I will look. The Skin Audits are on the MAR (Medication Administration Record) and the system is supposed to trigger the skin Audit/Body, but it hasn't been doing that. h. On 07/20/20 at 01:52 PM, RN #1 was asked, Did you notify the physician about Resident #83's wounds on the toes. RN #1 replied, No. RN #1 was asked, Has the Physician/APRN been notified of Resident #83 wounds on his toes? RN #1 replied, No. RN #1 was asked, Is there an order for [REDACTED].#1 replied, No. RN #1 was asked, Do you know when Resident #83 got the wounds on his toes? RN #1 replied, I think about 1 month ago. RN #1 was asked, Do you know how Resident #83 got the wounds on his toes? RN #1 replied, I'm not sure. RN #1 was asked, Would you treat the wounds on the toes? RN #1 replied, I haven't been, I just been letting it dry up. i. On 07/21/20 at 10:09 AM, the DON was asked, Should there be an order for [REDACTED]. j. On 07/21/20 at 10:20 AM, the Administrator was asked, Should there be an order for [REDACTED]. k. A policy titled, Wound Care Protocol provided by the DON on 7/20/20 documented, It is the policy of . that staff follow a consistent wound care protocol . to provide optimum skin care . Obtain Physician order . wound assessments done weekly until wound is healed .
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 restorative services was provided to prevent further decline in range of motion for 1 (Resident #12) of 4 (Residents #12, 19, 32, and 120) case mix residents who had physician orders [REDACTED].#12 had [DIAGNOSES REDACTED]. The Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 07/09/20 documented the resident scored 9 (8-12 indicates moderately impaired) on the Brief Interview for Mental Status (BIMS), was totally dependent of one person for personal hygiene and required extensive assistance of 2 plus people for bed mobility, transfer and toileting. a. Physician order [REDACTED].Restorative: Upper right extremities exercises and splint 3 x(times) a week, without a stop date . Restorative: Lower Paddle Bike x 10 minutes 3 x a week without stop date . Restorative: Upper and lower extremities exercises x 20 reps (repetition) each, 3 x a week with no stop . b. The Care Plan with a review date of 1/24/20 documented, Resident requires assistance with adls (activities of daily living) r/t (related to) Immobility syndrome and is at risk for complications r/t ADL dependence and impaired mobility . Unable to tolerate application of splint to rt wrist r/t pain (discontinued). Receives ROM exercises on BUE (bilateral upper extremities) including hands and fingers from Restorative aides. Attempt to place hand carrot in right hand . Approaches . Provide gentle range of motion to upper extremities including hands and fingers. Attempt to place washcloth or hand carrot in right palm . c. A July 2020 Activities of Daily Living form documented, Attempt to place hand carrot on rt (right) hand if he will allow it . There was no documentation on this ADL form to indicate any attempt to place the carrot in the right hand from 7/1/20 to 7/16/20. d. On 07/13/20 at 01:44 PM, the resident was lying in bed with eyes open with right hand [MEDICAL CONDITION] without a device in the right hand. e. On 7/14/20 at 9:24 AM, the resident lying in bed on the right side with eyes closed with a right-hand [MEDICAL CONDITION] without a device in the right hand. f. On 7/16/20 11:30 AM, record review of Restorative Notes documented, Week of 5/11/20- contains no documentation of restorative assistance, Week of 5/18/20-contains no documentation of restorative assistance, Week of 5/25/20- contains documentation of receiving only 1 day of therapy and refused 1 day, Week of 6/1/20-received 1 day and refused on 6/5/20, Week of 6/8/20-received only 2 days of therapy, Week of 7/6/20-refused 1 day and received 1 day. g. On 7/16/20 at 12:34 PM, an interview was conducted with Restorative CNA #1. She was asked, Do you have documentation where you do restorative exercises? She stated, Yes, I have a book, if they refuse, I put in the computer and why they refuse and do a weekly summary on the computer. She was asked, How often is Resident #12 supposed to be getting restorative exercises? She stated, Three times a week. She was asked, What happened to the other times Resident #12 did not get the restorative? She stated, They pull the girls to work the floors . She was asked, Is Resident #12 supposed to have a splint on the right hand? She stated, He's not supposed to have it on . h. On 7/16/20 at 12:56 PM, the Director of Nursing was asked, Where is the documentation of the attempt to use the carrot? She stated, It won't be unless like a nurse writes a narrative .
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 transfer was performed according to the manufacturer's guidelines to prevent potential injury for 1 (Resident #85) of 1 sampled resident. This had the potential to affect 4 residents residing on the 200 hall who were transferred with mechanical lifts, based on a list provided by the Administrator on 7/20/20 at 4:55 p.m. Failed to ensure the environment remained as free of hazards as possible, as evidenced by failure to ensure potentially hazardous materials were stored in a secure location and that equipment and furniture were free from rips and tears on 4 halls (100 hall, 200 hall, 300 hall, and 400 hall) of 4 halls to prevent potential accidents and or injuries. Also failed to ensure medication was not left unattended on the medication cart to prevent potential accidents. This failed practice had the potential to affect 19 residents who were independently mobile and cognitively impaired as identified on the list provided by the Administrator on 7/21/20 at 9:38 a.m. The findings are: 1. Resident #85 had [DIAGNOSES REDACTED]. The Quarterly Minimum Data Set (MDS) with an assessment reference date (ARD) of 6/1/2020 documented the resident scored 2 (0-7 indicates severe impairment) on a Brief Interview for Mental Status (BIMS) and was totally dependent on the assistance of 2 plus people for bed mobility and transfers. a. The care plan dated 6/1/20 documented resident was at risk for falls and Transfers with assist x (times) 2 and full mechanical lift. b. On 7/14/20 at 1:50 p.m., Certified Nursing Assistant (CNA) #1 and CNA #2 used the mechanical lift to transfer Resident (R) #85 from the bed to the Geri-chair. The base of the lift was not opened when the lift was positioned under the bed. R#85 was lifted up and the lift was backed out from under the bed, and then moved to the foot of the bed where the Geri-chair was located. At this time, the base was opened to go around the Geri-chair and R#85 was lowered into the Geri-chair. CNA #1

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045452	A. BUILDING _____ B. WING _____	07/21/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
LAWRENCE HALL HEALTH & REHABILITATION	1051 WEST FREE STREET WALNUT RIDGE, AR 72476

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F 0689 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 6) was asked, When was the last training on the mechanical lift? She stated, We had a skills fair not long ago, I don't remember the date. CNA #2 was asked about the last training. She stated, Probably a month ago. c. On 7/16/20 at 8:16 a.m., a review of the Mechanical Lift Operating Manual documented, Transfer from a bed . Move the mechanical lift into position with the bar assembly about 15 inches above the patient's stomach . Open the base to its widest position. d. On 7/20/20 at 12:40 p.m., the Director of Nursing (DON) was asked when transferring a resident from the bed to the chair what position should the base be in? The DON stated, They're supposed to have the legs open when lifting. 2. On 7/16/20 at 10:30 a.m., during the medication pass, Licensed Practical Nurse (LPN #3) removed a container of Artificial tears (for Resident #85) from a drawer on the medication cart and placed it on top of the cart. The LPN left the artificial tears on top of the cart and went into the resident's room and closed the door, to administer the enteral medications to the resident. The cart was not visible to the LPN. 3. Resident #20 had [DIAGNOSES REDACTED]. The Minimum Data Set assessment dated [DATE] documented the resident was severely impaired for cognitive skills for daily decision making, required extensive assistance of one person for transfers, and is at risk of developing pressure ulcers/injuries. a. On 07/13/20 at 11:43 AM, a spray bottle labeled [MEDICATION NAME] wound cleanser was sitting on the resident's bedside table. b. On 07/13/20 at 11:50 AM, the Restorative CNA was in the room to assist resident with lunch. She was asked if she knew what was in the spray bottle. She stated, .I have no idea . c. On 07/13/20 at 11:52 AM, Licensed Practical Nurse (LPN) #1 was asked, Can you tell me what is that on the bedside table? She stated, Wound cleanser. She was asked, Is it usually kept at the bedside? She stated, It shouldn't be . I'm going to go give it to the treatment nurse. The surveyor went with the LPN who could not locate the treatment nurse at this time. She stated, I'm going to take it to my office till I can find her. d. On 07/16/20 at 3:31 PM, the DON was asked, Where is wound cleanser usually stored? She stated, In the treatment cart or office, not in the room . 4. Resident #56 had [DIAGNOSES REDACTED]. The MDS with an ARD of 5/21/2020, documented the resident scored 14 (13-15 indicates cognitively intact) on the BIMS, required extensive assist of 2 persons for bed mobility, transfer, dressing, toilet use, supervision for eating, and was occasionally incontinent of bladder. On 07/13/2020 at 12:01 PM, a tube of [MEDICATION NAME] with 16.5 % Zinc Oxide was sitting on the windowsill. 5. Resident #63 had a [DIAGNOSES REDACTED]. The Quarterly MDS with an ARD of 5/26/2020, documented the resident scored 6 (0-7 indicates severe impairment) on the BIMS. On 07/13/2020 at 11:20 AM, Resident #63 was sitting in a recliner in her room. A tube of [MEDICATION NAME] with Zinc Oxide 16.5% was on the counter by the sink in her room. 6. On 07/13/2020 at 12:44 PM, a black metal mailbox with lid, was hanging on the wall outside 400 Hall nurses' station. The lid had approximately 1 inch of metal protruding outward. The corners were sharp and pointed. A photo was taken at this time. 7. On 07/13/20 at 01:36 PM, the bottom corner of the 300 Hall Nurses station, facing the hallway, had hard plastic that was ripped approximately 6 inches, with sharp, pointed, and protruding edges. A photo was taken at this time. 8. On 07/13/2020 at 02:15 PM, the door on room [ROOM NUMBER] had hard plastic molding, 6 inches high from the bottom, that was 1.5 inches wide, broken, with sharp edges and protruding outward 1 centimeter. 9. On 07/21/20 at 10:09 AM, the DON was asked, Should the metal mailbox with protruding corners, the 200 room door with protruding hard plastic, and the corner of the 300 Hall nurses station desk, with hard protruding plastic, be in the facility? The DON replied, No. The DON was asked, Would the mailbox, door, and corner of nurses station be considered a hazard? The DON replied, Yes. 10. 07/21/20 at 10:20 AM The Administrator was asked, Should the metal mailbox with protruding corners, the 200- room door with protruding hard plastic, and the corner of the 300 Hall nurses station desk, with hard protruding plastic, be in the facility? The Administrator replied, No. The Administrator was asked, Would the mailbox, door, and corner of nurses station be considered a hazard? The Administrator replied, Yes. 11. Resident (R) #32 has [DIAGNOSES REDACTED]. The Quarterly MDS with an ARD of 5/1/20 documented the resident scored 15 (13-15 indicates cognitively intact) on the Brief Interview for Mental Status (BIMS). a. On 07/14/20 at 11:20 AM and 07/13/20 at 12:44 AM, the resident was sitting in a wheelchair brushing her dentures at a sink. R32 had a (1.76 oz) blue bottle of [MEDICATION NAME] Cough Suppressant Topical [MEDICATION NAME] Ointment sitting in a blue recliner. The resident was asked if the medication was hers and stated, Yes, I use it for my throat, nose and chest. b. On 07/20/20 at 4:26 PM, the DON was asked, Should a resident have Vicks [MEDICATION NAME] out in room? She stated, Not out available to anybody. She was asked, What is the potential negative outcome? She stated, Cognitively impaired residents could get a hold of it. 12. Resident #118 had [DIAGNOSES REDACTED]. The MDS with an ARD of 6/29/20 documented the resident scored 15 (13-15 indicates cognitively intact) on the Brief Interview for Mental Status (BIMS). a. On 07/15/20 at 9:28 AM, and 7/17/20 at 9:53 AM, the resident was lying in bed with eyes open with a 4-ounce Icy Hot Maximum Strength Dry Spray 16 % Menthol and bottle of Rexall Medicated Chest rub sitting on the bedside table. b. On 7/17/20 at 10:30 AM, record review of the July 2020 Physician order [REDACTED]. Resident may keep in room (in locked box) . c. On 7/17/20 at 10:38 AM record review of the Care Plan documented, Resident is alert and oriented. She request and is able to administer her own muscle rub with menthol. Medications are kept in security box in room . Key for lock box kept with resident, medication kept in lock box. d. On 07/20/20 at 4:26 PM, the DON was asked, Should muscle rub with menthol be kept in a locked box according to the Physician orders [REDACTED]. She was asked, Should the resident's menthol rub be kept on the bedside table? She stated, No. She was asked, Should the Physician orders [REDACTED].
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 the respiratory accessories (cannulas, updraft, mask and tubing) items was stored in a bag or other closed container when not in use to prevent potential contamination or infection for 1 (Resident #5) of 12 (Residents #5, 100, 96, 71, 120, 60, 66, 94, 83, 63, 67 and 113) who used respiratory equipment, and the facility failed to ensure the flow rate was accurate for 1 (Resident #31) of 13 (Residents #31 #5, 100, 96, 71, 120, 60, 66, 94, 83, 63, 67 and 113) who received oxygen therapy. These failed practices had the potential to affect 30 residents who had physician's orders [REDACTED]. Resident #5 [DIAGNOSES REDACTED]. The Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 04/10/2020 documented the resident scored 15 (13-15 indicates cognitively intact) on the Brief Interview for Mental Status (BIMS). The resident required extensive assistance physical assist with bed mobility, transfers, dressing, toilet use and bathing and received oxygen while a resident. a. The July 2020 Physician order [REDACTED]. change updraft biweekly and prn (as needed) also change respiratory bag and date. Clean [MEDICAL CONDITIONS] and trilogy tubing and masks weekly and prn as needed . Oxygen accessories in bag - make sure cannulas, updraft, [MEDICAL CONDITIONS] and Trilogy items are in the respiratory bag when resident not using. b. On 7/13/20 at 01:15 PM, Resident #5 was lying in bed, oxygen mask in place at a rate of 5.5 liters per minute (lpm). Portable oxygen tank located on the back of the wheelchair, Resident #5 stated, she gets up in the wheelchair when she feels like it, I was up earlier this morning. Oxygen tubing and mask attached to the portable oxygen tank was not in a bag. They were hanging on the top of the oxygen tank. Trilogy machine present at the bedside. Resident #5 stated, I use it while I sleep because I stop breathing. The tubing and the mask to the trilogy machine was lying in a bucket of snacks. The mask and tubing were not in a bag. Photo were taken at this time. c. On 7/14/20 at 02:54 PM, the resident was lying in bed, oxygen being administered through Venturi mask at 5 lpm. The tubing and the mask for the trilogy machine are laying on the bedside table not in a bag. There was a white substance inside the mask for the trilogy machine. A nebulizer machine, tubing and mask was resting on top of the resident's refrigerator and the mask and tubing were not in a bag. Resident #5 stated, I do not use the nebulizer very often, but it is there if I need it. The trilogy machine is cleaned 1 time a week and the filter are changed 1 time a month. A portable oxygen tank was on the back of the wheelchair. The tubing and the mask were hanging on the portable oxygen tank and were not in a bag. d. On 7/16/20 at 08:32 AM, the resident's trilogy mask was laying on the bedside table, and there was no date located on the mask. The mask and tubing were not in a protective bag. e. On 07/16/20 at 2:27 PM, the Director of Nursing (DON) was asked where the nebulizer mask, oxygen mask, oxygen tubing and the Trilogy mask and tubing should be placed when not in use? The DON stated, They should be placed in the bag. The DON was asked when the trilogy mask should be cleaned or replaced? The DON stated, When it gets dirty but the resident eats and gets it dirty, but it should be cleaned when dirty. f. On 7/16/20 at 4:00 PM the Care Plan documented, Updrafts as ordered, attempt to place oxygen tubing, updraft tubing in oxygen bag when not in use . g. The Trilogy Machine infection control practice obtained from DON on 07/15/2020, documented the tubing and mask used for the trilogy machine will be cleaned with soapy water once weekly and more frequently as required or needed. h. The Oxygen Equipment Change out policy

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	045452	A. BUILDING _____ B. WING _____	07/21/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
LAWRENCE HALL HEALTH & REHABILITATION	1051 WEST FREE STREET WALNUT RIDGE, AR 72476

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F 0695 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 7) given by the respiratory department on 07/15/2020 at 9:45 am documented, It is the policy of (facility) to assure that good infection control practices are followed. The oxygen tubing change-out schedule is as follows: The oxygen tubing (cannulas and masks) is changed out weekly and PRN as needed. All tubing is tagged with a green sticker with the current change out date. Nebulizer set-ups are changed twice weekly and PRN as needed. All bags and tubing are tagged with a green sticker with a current change out date. 2. Resident #31 had [DIAGNOSES REDACTED]. The MDS assessment dated [DATE] documented the resident was moderately impaired in cognitive skills for daily decision making per the staff assessment for mental status and received oxygen therapy while a resident. a. The physician's orders [REDACTED].oxygen 2-4 liters per NC (nasal cannula) continuous . b. The resident's care plan documented, .Potential for impaired O2 (oxygen) exchanged r/t (related to) [MEDICAL CONDITIONS], [MEDICAL CONDITIONS] . Medication as ordered . c. On 7/13/20 at 11:18 AM, 07/14/20 at 09:25 AM, and 7/15/20 at 8:39 AM, the resident was resting in bed, oxygen being administered per nasal canula via a concentrator set to administer at 1.5 liters per minute. His respirations were even and non-labored. d. On 07/15/20 at 08:42 AM Licensed Practical Nurse (LPN) #4, was asked at what rate was the oxygen set. She stated, It's on 1.5. She was asked what it is supposed to be set on. She stated, I am thinking it is 2 to 4, I will have to look . After checking the orders, she stated, .2-4 .I'm going to go fix that . e. On 07/16/20 at 3:31 PM the Director of Nursing was asked, If a resident has an oxygen order for 2-4 liters per minute, should it be set at 1.5 liters per minute? She stated, No, it should be set at 2-4 .
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 currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.** Based on observation and interview, the facility failed to ensure medications were labeled and stored in accordance with State law and accepted standards of pharmacy practice, to assure efficacy of the medications and prevent potential administration of outdated medications in 1 (100-hall medication cart) of 4 (100, 200, 300 and 400 hall) medication carts. The findings are: 1. On 7/17/20 at 7:35 AM, the 100-hall medication cart was inspected with LPN #4 in attendance. There was one vial of open insulin in the cart. The opened date was not identified on the bottle. Photo taken of the insulin bottle. LPN #4 was asked. Should it (vial of insulin) be dated? She stated, Yes, I'll throw it away after my medication pass. 2. On 7/20/20 at 12:58 p.m., the Director of Nursing was asked, Should insulin be dated when it's opened? She stated, Yes.
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 approved, planned, written menu signed by the Dietitian, to meet the nutritional needs of the residents who received mechanically altered meals for 1 of 1 meal observed from 1 of 1 kitchen. This failed practice had the potential to affect 15 residents who received a pureed diet and 21 residents who received mechanical soft diets, according to the list provided by Food Service Supervisor dated 7/16/2020 at 2:15 pm. The findings are: 1. On 7/15/2020, the facility's Spring/Summer 2020 menu for the lunch meal documented for residents on pureed diets to receive 4 ounces (oz) of pureed country fried chicken, cup of mashed potatoes and cup of pureed Brussels sprouts. 2. On 7/15/20 at 9:48 am, Dietary Employee #4 placed 24 pieces of chicken fingers into a blender and ground. She poured the ground chicken fingers into a pan. She covered the pan with a piece of foil and placed it in the oven to be served to 21 residents who received mechanical soft diets, instead of the required 42 pieces of chicken fingers. 3. On 7/15/2020 starting at 9:50 am, the following observations were made during the lunch meal preparation: She placed 7 chicken patties into a blender. At 9:54 am, she added 2 pieces of chicken fingers. The surveyor asked for a chicken patty and the chicken fingers to be weighed. The chicken patty weighed 3 oz and two pieces of chicken fingers weighed 3 1/4 oz and were placed back in the blender. At 9:55 am, she added warm broth and then pureed. Dietary Employee #4 poured the pureed chicken mixture into a pan. She covered the pan with a piece of foil and placed it in the oven. A total of 9 servings of chicken were prepared to serve 15 residents who required pureed diets for lunch, instead of 15 servings. 4. On 7/15/20 at 11:11 am, the following observations were made during the lunch meal service for the residents on pureed diets and the residents on mechanical soft diets: a. Dietary Employee #4 used a #30 scoop, which was equivalent to 1.07 oz, to serve a single portion of pureed chicken meat to the residents on pureed diets, instead of using a #6 scoop (6 oz) to serve pureed country fried chicken as specified on the menu. b. Dietary Employee #4 used a #16 scoop to serve a single portion of pureed vegetables which was equivalent to 1/4 cup, instead of using a cup as specified on the menu. c. Dietary Employee #4 used a #20 scoop to serve a single portion of ground chicken fingers which was equivalent to 1.60 oz, instead of using a #8 scoop (4 ounces) to serve ground country fried chicken as per the menu. d. Dietary Employee #4 used a #10 scoop to serve a single portion of power potatoes which was equivalent to 3 oz, instead of using cup= 4 oz to serve power potatoes as specified on the recipe provided by Registered Dietitian on 7/16/2020 at 10:03 a.m. e. On 7/15/20 at 12:43 pm, Dietary Employee #5 was asked to weigh the amount of pureed country fried chicken portioned on a plate to serve to the resident. Which she did and it weighed 1.75 oz, instead of #6 scoop (6 oz) as specified on the menu. f. On 7/15/20 at 12:50 pm, the Food Service Supervisor was informed about scoop sizes used to serve pureed food items for lunch. She stated, They supposed to have 3 ounces of meat, 1/2 cup of pureed vegetables and 4 oz of power potatoes. g. On 7/16/2020 at 8:25 am, Dietary Employee #4 stated, I gave only a serving. I did not have the right scoops available to use. I did 24 pieces of chicken fingers for the ground meat.
F 0806 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interview, the facility failed to ensure residents were served dietary preferences according to likes and dislikes for 3 residents (Residents #67, #56, #113) of 9 (Residents #63, #67, #113, #83, #56, #25, #27, #81, and #173) sample residents on the 400 Hall. This failed practice had the potential to affect 26 residents on the 400 Hall who receive meal trays from the kitchen according to a list provided by the Administrator on 7/21/2020 at 8:14 am. The findings are: 1. Resident #67 had a [DIAGNOSES REDACTED]. The Quarterly Minimum Data Set (MDS) documented the resident scored 15 (13-15 indicates cognitively intact) on the Brief Interview for Mental Status (BIMS) and required supervision for eating, a. A physician order [REDACTED].Regular diet . b. A Grievance Log dated 5/24/2020 documented, .resident was sent food during breakfast that she did not like .Tray line education to honor preferences . c. A Grievance Log dated 5/27/2020 documented, .had pureed fish sticks and she does not like fish. This is listed on her meal ticket under the dislikes list . tray line employees educated to watch meal tickets closer per likes and dislikes . d. On 07/14/2020 at 09:30 AM, Resident #67 was sitting up in bed, eating breakfast. A fried egg was on the meal tray. Resident #67 meal card read: allergies [REDACTED]. Resident #67 was asked, Do you like fried eggs? Resident # 67 replied, I don't like eggs. e. On 07/14/2020 at 09:50 AM, Certified Nursing Assistant (CNA) #5 was asked, Should residents receive dietary preferences? CNA #5 replied, Yes. CNA #5 was asked, Should residents receive dislikes on their meal tray? CNA #5 replied, No. CNA #5 was asked, if she knew what to do if a resident received a disliked food on their meal tray. She replied, Usually we report it, we call the kitchen, I did not call the kitchen. f. On 07/14/2020 at 10:08 AM Dietary Employee #1 was asked, Have you had any reports this morning of any residents being sent dietary dislikes and not receiving dietary preferences? Dietary Employee #1 replied, I have not. 2. Resident #56 had [DIAGNOSES REDACTED]. The Quarterly MDS with an Assessment Reference Date (ARD) of 5/21/2020, documented the resident scored 14 (13-15 indicates cognitively intact) on the BIMS and required supervision for eating, a. A physician order [REDACTED].Diet .Regular NAS (no added salt) .Super Foods TID (three times daily) . b. The Care Plan revised February 2020 documented, .Potential for weight loss related to [MEDICAL CONDITIONS] .Determine food

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	045452	A. BUILDING _____ B. WING _____	07/21/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
LAWRENCE HALL HEALTH & REHABILITATION	1051 WEST FREE STREET WALNUT RIDGE, AR 72476

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 0806 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 8) preference . Provide diet as ordered . Add preferences to resident meal ticket . c. On 07/14/20 at 09:21 AM, Resident #56 was sitting up in bed, eating breakfast. A carton of 240 cc (cubic centimeter) of milk was on the resident's tray. The resident's tray card read: allergies [REDACTED]. Resident #56 was asked, Do you like milk for breakfast? She replied, Not necessarily. The tray card also read: Beverages/Equipment: Juice Orange (4 ounces). There was no orange juice on the resident's tray. She was asked, Did you get orange juice this morning for breakfast? She replied, No I didn't. d. The facility menu dated 7/13/2020 read, Breakfast: Orange Juice, 6 fluid ounces. e. On 7/14/20 at 09:50 AM, Certified Nursing Assistant (CNA) #5 was asked, Should residents receive dietary preferences. CNA #5 replied, Yes. CNA #5 was asked, should resident receive dislikes on their diet meal tray? CNA #5 replied, No. CNA #5 was asked, What do you do if a resident receives something they don't like or don't receive something they prefer? CNA #5 replied, Usually we report it, we call the kitchen, I did not call the kitchen. 3. Resident #113 had [DIAGNOSES REDACTED]. The MDS with an ARD of 6/24/2020, documented the resident scored 7 (0-7 indicates severe impairment) on the BIMS and required extensive assist of 2 persons for eating and personal hygiene, a. A physician order [REDACTED].Diet .Puree . b. The Care Plan documented, .Potential for weight fluctuation related to [DIAGNOSES REDACTED]. provide diet as ordered . determine food preference . c. On 07/13/2020 at 12:53 PM, CNA #7 assisted the resident with the meal tray set up. Resident #113 Lunch Meal Ticket dated 7/13/2020 documented, Beverages/Equipment: Water. Resident #113 meal tray contained 240 cc glass of tea and no water. CNA #7 was asked, Is Resident #113 supposed to have water? CNA #7 replied, .they usually send mini bottles of water if the ticket says water. CNA #7 was asked, Who is responsible for ensuring water is on the trays? CNA #7 replied, That's part of the tray line job. d. On 7/13/2020 at 01:02 PM, Dietary Employee #3 was asked, Who is responsible for ensuring residents receive water on their meal tray? Dietary Employee #3 replied, The tray line fills the tickets per preference. Dietary Employee #3 was asked, If the resident's preference was water, then should there be water on the tray? He replied, Yes. Dietary Employee #3 was asked, Should there have been water on Resident #113 tray? He replied, Yes. e. On 07/21/20 at 10:09 AM, The Director of Nursing (DON) was asked, Should residents be served their dietary preferences? The DON replied, Yes.
F 0812 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**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 food items stored in the refrigerator were, labeled and dated; expired food items were promptly removed/ discarded by the expiration or use by dates, and foods were dated as when received to assure first in first out usage to prevent potential for food bone illness; ice machines were maintained in clean and sanitary condition to prevent contamination of airborne particles; 38 residents who received ice from 100 Hall, 33 residents who received ice from 200 Hall, 29 residents who received ice from 300 Hall and 23 residents who received ice from 400 Hall, as documented on the list provided by the DON on [DATE] at 9:02 am.; and food items stored in the refrigerator were covered or sealed to prevent potential food borne illness for residents who received meals from 1 of 1 kitchen; and dietary staff washed their hands before handling clean equipment or food items to prevent potential food borne illness for residents who received meals from 1 of 1 kitchen and cold foods was maintained at or below 41 degrees Fahrenheit on the meal tray serving to prevent potential food borne illness for residents who received meals from 1 of 1 kitchen. Theses failed practices had the potential to affect 129 residents who received meals from the kitchen (total census:123), as documented on a list provided by Registered Dietitian on [DATE] at 8:36 am and the findings are: 1. On [DATE], two (3-pound bags) of apple slices were on a shelf in the storage room. The label on the bags documented use by [DATE]. 2. On [DATE] at 12:01 pm, 13 (2-pound cartons) of Fresh start whole eggs with citrus acid were on shelf in the refrigerator with an expiration date of [DATE]. 3. On [DATE] at 12:18 pm, Dietary Employee #1 was on the tray line assisting with the meal service. She touched her mask which contaminated her hand. She then, used her contaminated gloved hand to pick up lids and placed them over the glasses that contained fluids to be served to the residents for lunch with gloved fingers touching the inside surfaces of the lids. 4. On [DATE] at 12:21 pm, there were 2 containers of leftover slices of turkey meat on a shelf in the refrigerator. There was no date on the container as when it was prepared. 5. On [DATE] at 12:25 pm, a turkey sandwich wrapped in foil was on a shelf in the refrigerator. There was no date on the foil as when it was prepared. 6. On [DATE] at 8:25 am, there was black residue on the panel of the ice machine in the kitchen. The Food Service Supervisor was asked to wipe the black residue on the panel of the ice machine. She did so, and the black residue was easily transferred to the rag. The Food Service Supervisor was asked to describe the appearance of the ice machine panel. She stated, It's was black mold. The Food Service Supervisor was asked who used the ice from the machine and how often do you clean the ice machine. She stated, We clean it every Monday. We use it in the kitchen to fill tea served to the residents at mealtimes. 7. On [DATE] at 8:30 am, the following observations were made: a. There was an open box of diced chicken crisp on a shelf in the walk-in freezer. The box was not covered or sealed. b. A box of chicken Crispitos were on a shelf in the walk-in freezer. The box was not covered or sealed. c. There were 2 boxes of omelet on a shelf in the walk-in freezer. The boxes were not covered or sealed. d. A box of hash brown and 2 boxes of hamburger patties were on a shelf in the walk - in freezer. The boxes were not covered or sealed. 8. On [DATE] at 8:45 am, Dietary Employee #2 was wearing gloves while placing slices of peaches in individual bowls. She was told by the Dietitian to put on her mask. She did so without changing gloves and washing her hands, then she picked up bowls to be used to serve dessert and placed them on the tray with her gloved fingers in the bowls. 9. On [DATE] at 8:47 am, Dietary Employee #2 was wearing gloves when she picked up a can of peaches and placed it on the counter. Dietary Employee #2 did not wash her hands or change gloves before she picked up clean bowls with her gloved fingers inside the bowls and placed them on the tray to be used to portion dessert to be served to the residents for lunch. 10. On [DATE] at 8:51 am, Dietary Employee #2 was wearing gloves on her hands when she picked up a lid from the floor and threw it away and then pulled her blouse down. Without changing gloves and washing her hands, she picked up clean bowls from the tray and placed them on the counter to portion peach halves to be served to the residents for lunch while doing so, she was touching the inside surface of the plates with her contaminated hand. 11. On [DATE] at 9:18 am, Dietary Employee #3 was wearing gloves and she pushed food carts towards the sink. Without changing gloves and washing her hands, she picked up clean dishes and stacked them on the plate warmer with her fingers touching the surfaces of the dishes. 12. On [DATE] at 9:28 am, Dietary Employee #3 was wearing gloves on her hands and used a rag to clean food carts, without changing gloves and washing her hands, she picked up clean dishes and placed them on the plate warmer with her fingers touching the inside surfaces of the dishes. At 10:27 am, Dietary Employee #3 was asked, what should you have done after touching dirty objects and before handling clean equipment. She stated, I should have removed the gloves and washed my hands. 13. On [DATE] at 9:30 am, Dietary Employee #2 was wearing gloves on her hands when she touched her mask, without changing gloves and washing her hands, she removed shredded lettuce, tomatoes and shredded cheese from different container and placed them in individual plastic bowls to be served to the residents who requested for salad with their lunch meal. 14. On [DATE] at 9:32 am, Dietary Employee #4 turned off the sanitizer knob on the wall above the 3 compartments sink with her bare hand, contaminating her hand. Without washing her hands, she picked up a clean blade and attached it to the base of the blender to be used in pureeing food to be served to the residents on pureed diets. 15. On [DATE] at 9:33 am, Dietary Employee #4 used her gloved hand to keep Brussel sprouts from falling from the spoon as she used an 8 oz spoon to spoon 5 servings into a blender, added brown sugar and melted butter and pureed. She placed her gloved hand into the blender, adjusted the blade that popped up and continued pureeing the Brussel sprouts. 16. On [DATE] at 11:24 am, there was corroded brown matter on the inside lid of the Ice machine located in the dining room on the 100 Hall. The Food Service Supervisor was asked to wipe the brown residue on the panel of the ice machine. She did so, and the brown residue easily transferred to the rag. The Food Service Supervisor was asked to describe the appearance of the ice machine panel. She stated, It was brown matter. The Food Service Supervisor was asked who used the ice from the machine and how often do you clean the ice machine. The Food Service Supervisor stated, That's the ice the CNAs (Certified Nursing Assistants) use for the water pitchers in the residents' rooms. 17. On [DATE] at 11:27 am, there was black residue on the ice machine panel located in room behind the nurses' station. The Food Service Supervisor was asked to wipe the black residue on the panel of the ice machine. She did so, and the black residue easily transferred to the rag. The Food Service Supervisor was asked to describe the appearance of the ice machine panel. She stated, It is black in color. The Food Service Supervisor was asked who used the ice from the machine and how often do you clean the ice machine. She stated, The janitor. That's the ice the CNAs (Certified Nursing Assistants) use for the water pitchers in the residents' rooms. 18. On [DATE] at 11:33 am, there was brown residue on the panel of the Ice machine in the dining room for ,[DATE] halls. The Food

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F 0812 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 9) Service Supervisor was asked to wipe the brown residue on the panel of the ice machine. She did so, and the brown-residue easily transferred to the rag. The Food Service Supervisor was asked to describe the appearance of the ice machine panel. She stated, It's was brown in color. The Food Service Supervisor was asked who used the ice from the machine and how often do you clean the ice machine. She stated, The janitor. That's the ice the CNAs (Certified Nursing Assistants) use for the water pitchers in the residents' rooms. On [DATE] at 9:00 am, the Administrator was asked how often you clean the ice machine. She stated, The Janitor cleans it every week. 19. On [DATE] at11:36 am, the following observations were made in the refrigerator or in the freezer on the unit. a. An open bag of dinner rolls was on a shelf in the refrigerator. An open carton of ice cream was on a shelf in the freezer. b. A 3-gallon container of chocolate ice cream was on a shelf in the freezer. The box was not properly sealed exposing it for freezer burn. The Food Service Supervisor was asked to describe the appearance of the ice cream. She stated, It has freezer burn. 20. On [DATE] at 12:25 AM, Dietary Employee #5 had gloves on her hands while on the tray line serving the meal. She picked up serving spoons and served food items with them. She then, used her contaminated hand to pick up slices of bread and placed them on trays to be served to the residents for lunch.
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 wore face masks and / or wore face masks correctly to prevent potential cross-contamination and spread of COVID-19 or other infections. This failed practice had the potential to affect all 123 residents, according to the Resident Census and Condition of Resident Report provided by the Administrator on 7/13/20. The findings are: 1. On 07/14/2020 at 10:01 AM, Certified Nursing Assistant (CNA) #3 was observed going in and coming out of different residents' rooms on the 300 Hall with the face mask not covering the nose. On 07/14/2020 at 10:50 AM, CNA #3 was in room [ROOM NUMBER], assisting residents, and the face mask was not covering her nose. CNA #3 was asked, should staff wear face masks and should they (face masks) cover the mouth and nose. CNA #3 stated, Yes. CNA #3 was asked, would not covering your nose with a face mask be considered an infection control issue. CNA #3 stated, Yes. 2. On 07/16/20 at 08:45 AM, Licensed Practical Nurse (LPN) #3 was observed standing in the hall, at the medication cart, with the face mask not covering the mouth or nose. Another staff member was standing within 6 feet of the LPN. LPN #3 was asked, should face masks be covering the nose and mouth. LPN #3 stated, Yes. LPN #3 was asked, would that be considered an infection control issue. LPN #3 stated, Yes. LPN #3 was asked, have you been trained and educated on COVID-19. LPN #3 stated, Yes. Surveyor took picture. 3. On 07/21/20 at 08:04 AM, CNA # 8 was observed, not wearing a face mask covering nose and mouth while assisting/pushing Resident (R) #107 outside in a wheelchair to the facility van. CNA #9 was observed walking next to CNA #8 and R #107 and not wearing a face mask covering the nose and mouth. CNA #8 was observed standing next to and assisting R#107 in the facility van, not wearing a face mask covering mouth and nose. CNA #8 was asked, are you supposed to be wearing a face mask covering your mouth and nose. CNA #8 stated, I did not have my mask on, it was halfway on. 4. On 07/21/20 at 10:09 AM, the Director of Nursing (DON) was asked, should staff wear face masks covering their mouth and nose. The DON stated, Yes. The DON was asked, would not wearing a face mask covering your mouth and nose be considered an infection control issue. The DON stated, Yes. 5. On 07/21/20 at 10:20 AM, the Administrator was asked, should staff wear face masks covering their mouth and nose. The Administrator stated, Yes. The Administrator was asked, would not wearing a facemask covering your mouth and nose be considered an infection control issue. The Administrator stated, Yes. 6. On 07/15/2020 at 8:20 AM, when the surveyor entered the kitchen, Dietary Employees #1, #2, #4, #6, and #7 did not have face masks on. 7. On 07/15/20 at 10:19 AM, CNA #10 was observed standing in room [ROOM NUMBER] with a face mask on the face but not covering the nose. CNA #10 was asked, what is the appropriate way to wear a face mask? She stated, Over my nose. 8. On 07/20/20 at 3:00 PM, Dietary Employee (DE) #8 was observed in the kitchen, at a prep counter, preparing food for the supper meal with the face mask pulled to the mouth exposing the nose. The DE was asked, are you supposed to wear a mask that covers the nose? The DE stated, If we are closer than 6 feet, then yes. Are you preparing food for the residents? She stated, Yes. 9. On 07/20/20 at 4:26 PM, The DON was asked, should face masks cover the mouth and nose? She stated, Yes. Should staff have their mouth and nose covered with a mask when preparing the residents' food? She stated, Yes. 10. On 07/21/20 at 8:35 AM, a tour was conducted of the laundry room. An observation was made, on the dirty side of the laundry, of a red, biohazard trash bag with contents sitting out on top of a yellow mop bucket. Laundry Aide #1 was asked, is that biohazard trash sitting outside of a container on top of mop bucket? She stated, Yes. Is that a good idea? She stated, No. Picture was taken.
F 0925 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Make sure there is a pest control program to prevent/deal with mice, insects, or other pests.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the facility failed to ensure the kitchen was free of pest to prevent potential of cross contamination or bacteria growth. This failed practice had the potential to affect 120 residents who received food from 1 of 1 kitchen, according to the list provided by the Food service supervisor on 7/17/2020. The findings are: 1. On 7/15/20 at 8:50 am, a fly was on a cart where cans of chicken noodles were kept. 2. On 7/15/20 at 9:01 am, there were 5 flies flying around a dirty cart between the doors leading to the kitchen and the door leading to the dish washing room. 3. On 7/15/20 at 9:27 am, there was a fly on a rack where pans were stored. 4. On 7/15/20 at 9:56 am, one fly was on the pole attached to the plate warmer. The surveyor pointed it out to Dietary Employee #1. She stated, They are bad. The Food Service Supervisor stated, They come in when the door is open. 5. On 7/15/20 at 9:59 am, a fly was flying around a box of breast filet fritters on the counter. 6. On 7/15/20 at10:00 am, a fly was crawling on a bag of mashed potatoes on the counter. 7. On 7/15/20 at 10:01 am, a fly was crawling on top of the ground country fried chicken in a pan on the counter. Surveyor pointed it out to Dietary Employee #3 who chased it away. She then, scooped off the whole top of the ground country fried chicken and threw them away. 8. On 7/15/20 at 10:40 am, a fly was crawling on a piece of foil used to wrap a grilled cheese sandwich kept on the steam table. 9. On 7/15/20 at 10:44 am, a fly was on a tong inside a pan on the counter. It was sitting by an uncovered pan that had chopped chicken fingers in it. Surveyor pointed it out to Dietary Employee #3 who covered the pan with a piece of foil. 10. On 7/15/20 at 10:54 am, there was a fly on the steam table. Another fly was around the plate warmer. 11. On 7/14/20 at 1:41 PM, a (Company) Log Report received from the Interim Administrator dated 5/6/2020, 6/3/2020 and 7/2/202 documented the facility had received treatment for [REDACTED].