STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045455	A. BUILDING _____ B. WING _____	07/10/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
HICKORY HEIGHTS HEALTH AND REHAB, LLC	#3 CHENAL HEIGHTS DRIVE LITTLE ROCK, AR 72223

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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F 0570 **Level of harm -** Potential for minimal harm **Residents Affected -** Some	**Assure the security of all personal funds of residents deposited with the facility.** Based on record review and interview, the facility failed to ensure a Surety Bond, with an amount equal to at least the current total amount of the residents' funds ($67,686.46) was in place to guarantee that the facility would pay the resident (or the State on behalf of the resident) for losses occurring from any failure by the facility to hold, safeguard, manage, or account for the resident's funds for 16 (Residents #3, #10, #12, #16, #18, #24, #28, #29, #33, #35, #37, #40, #42, #55, #61 and #76) of 34 sampled residents who had a trust account managed by the facility. This failed practice had the potential to affect 50 residents who had a trust account managed by the facility, as documented on a list provided by the Business Office Manager (BOM) on 07/08/20 at 11:06 a.m. The findings are: 1. On 07/08/20 at 11:06 a.m., the BOM provided a Surety Bond that documented the following, (Company) Insurance . Date February 11, 2020 . Re: Bond Rider . Type Bond: Patient Trust Bond Amount of Bond $30,000 Renewed from 01/27/20 to 01/27/21 . She also provided a list that documented, . Trust-Current Account Balance as of 07/08/2020 . Control Account Summary Trust Bank $67,686.46 . 2. On 07/09/20 at 10:45 a.m., the BOM was asked, Who is responsible for ensuring the amount in the Surety Bond is at least equal to the amount of total funds in the resident's trust account? She stated, This is my responsibility. I spoke with my Business Office Consultant and it was explained to me that the surety bond covers the deposits and not what is in the account. I did increase it because we have $25,800 in deposits and that's why it's only $30,000 not the entire balance of the account.
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 residents were provided with the opportunity to formulate an advance directive other than code status to enable residents to make advanced decisions about their care in the event of their incapacitation for 5 (Residents #10, #42, #45, #62 and #63) of 34 sampled residents, whose clinical records were reviewed for advanced directive information. This failed practice had the potential to affect 78 residents who resided in the facility according to the Resident Census and Conditions of Residents dated [DATE] at 1:22 P.M. The findings are: 1. Resident #63 had a [DIAGNOSES REDACTED]. a. The [DATE] physician order [REDACTED]. b. A care plan with the review date of [DATE] documented, . Code status is Full Code . The Advance Directive was not complete. c. On [DATE] at 2:50 P.M., the Administrator was asked, Do you have an Advanced Directive on file for (Resident #63)? She stated, I would have to look. The Administrator asked , Do you mean DNR (Do Not Resuscitate) or Full Code? The surveyor replied No, I mean something like life sustaining measures, living will, POA (Power of Attorney) . The Administrator stated, If we do, it would be scanned in to Point Click Care (PCC), and if it's not, then we don't have it. She was asked, Should the Advance Directive be completed? She stated, Yes. 2. Resident #10 had a [DIAGNOSES REDACTED]. a. On [DATE] at 10:12 A.M., a record review was completed and there was not an Advance Directive in the electronic chart. b. On [DATE] at 9:30 A.M., the Administrator stated the resident had no Advance Directive when the survey started but that he did now. She stated, It was just done this morning. 3. Resident #42 had [DIAGNOSES REDACTED]. A quarterly MDS documented the resident scored 9 (,[DATE] indicates moderate impairment) on a BIMS, required total care with locomotion, toileting, and bathing; extensive assistance with bed mobility, transfers, dressing, and personal hygiene. a. On [DATE] at 10:28 A.M., a record review was done, and no Advanced Directive could be found for the resident. b. On [DATE] at 9:03 A.M., the Administrator stated the resident did not have one. 4. Resident #45 had [DIAGNOSES REDACTED]. The Admission MDS with an ARD of [DATE] that also documented the resident scored 9 (,[DATE] indicates moderately impaired) on a BIMS. a. A Care Plan dated [DATE], documented, . code status is DO NOT RESUSCITATE (DNR) . Staff will acknowledge (Resident #45's) right to revoke DNR status at any time in any manner . b. On [DATE] at 8:48 P.M., the Electronic Clinical Record was reviewed and there was no Advance Directive or Admission documents to review for an Advance Directive. 5. Resident #62 had [DIAGNOSES REDACTED]. The Admission MDS with an ARD of [DATE], documented the resident scored 15 (,[DATE] indicates cognitively intact) on a BIMS. a. On [DATE] at 12:48 P.M., the Electronic Clinical Record was reviewed and there was a Code Status dated [DATE] that documented the resident did want CPR (Cardiopulmonary Resuscitation) but there was not an Advance Directive in the record. b. On [DATE] at 2:30 P.M., the Administrator was given a list with Residents #10, #42, #45, #62 and #63's names, and was asked for Advance Directives for the residents. c. On [DATE] at 9:03 A.M., the Administrator stated, There were no Advance Directives for these residents (referring to the list surveyor provided her on [DATE]) in the chart at this time. She was asked, So, there were none for all 5 residents? She stated, Yes . d. On [DATE] at 10:00 A.M., the Administrator provided a document titled Advance Directive that documented, 1. . Prior to, or upon admission, a representative of the social services department or designee will provide resident with written information concerning the resident's right under state law . the resident's right to prepare an advance directive . 4. A copy of the advance directive, if any will be included in the resident's medical record . 6. Social services/ (and or) designee will review advance directives annually with resident and/or legal representative .
F 0622 **Level of harm -** Potential for minimal harm **Residents Affected -** Some	**Not transfer or discharge a resident without an adequate reason; and must provide documentation and convey specific information when a resident is transferred or discharged.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Complaint # (AR 915) was substantiated, all or in part, with these findings: Based on record review and interview, the facility failed to include who initiated the discharge, who report was given to or what clinical information was provided to the receiving facility to promote continuation of care for 1 (Resident #79) of 4 (Residents #1, #2, #79 and #80) sampled residents who were discharged home or to another facility. This failed practice had the potential to affect 42 residents who were discharged home or to another facility between January 6, 2020 to July 6, 2020, as documented on a list provided by the Director of Nursing (DON) on 07/10/20 at 12:53 pm. The findings are: Resident #79 was admitted to the

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

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F 0622 **Level of harm** - Potential for minimal harm **Residents Affected** - Some	(continued... from page 1) facility on [DATE] as documented on an Admission Minimum Data Set with an Assessment Reference Date of 04/08/20 and the resident's overall expectation was to remain in the facility and the family or significant other provided this information for the assessment and goal setting. 1. A Social Note dated 04/16/20 at 15:33 (3:33 pm) documented, . (Name) from (Facility) of (City) contacted me asking if we are providing transport for pt (patient) to their facility. Informed her we do not provide transport for discharging pts. Called (Name) (dtr) (daughter) and informed her she would have to pick r (resident) up and transport her to (Facility) of (City) . Dtr stated she would be here shortly . There was no documentation in the resident's record of who initiated the transfer, who report was given to at the receiving facility or what clinical information was sent to the receiving facility. 2. A Nsg. (Nursing) - Discharge Instructions form, dated 04/16/2020 at 15:39 (3:39 pm) documented, . A. PATIENT INFORMAITON . 5. Resident will be residing where and with whom? r is discharging to (Facility) of (City) . 3. On 07/10/20 at 12:40 pm, the Administrator was asked, Do you know who initiated the discharge for (Resident #79), there was no documentation in the record? She stated, There wasn't a Social Note? Surveyor stated, There was, but there was no documentation on it regarding who initiated the discharge and it documented someone from the other facility called regarding if the resident would be transported by your facility? She stated, I'll have to check with (Social Director). A few minutes later the Administrator entered the Conference Room and stated, Her daughter initiated the transfer. 4. On 07/10/20 at 10:15 am, the DON was asked, When a resident is discharged to another facility, should the receiving facility be given the discharge information for the resident? She stated, Yes. We send over face (face sheet) and list of medication and give report, send progress notes and follow up appointments. She was asked, Should this be documented in the resident's record? She stated, Wouldn't write exactly what was sent. We would document destination and time left, and person leaving with.
F 0636 **Level of harm** - Potential for minimal harm **Residents Affected** - Some	**Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review the facility failed to ensure a Comprehensive Assessment was completed in a timely manner to facilitate the ability to develop plans of care to meet the residents' needs for 2 (Residents #3 and #39) of 34 sampled residents whose Minimum Data Set (MDS) assessments were reviewed. This failed practice had the potential to affect 78 residents who required MDS assessments as documented on the Resident Census and Condition of Residents dated 07/07/20 at 1:22 pm. The findings are: 1. On 07/09/20 at 4:57 P.M., Resident #3's MDS section was reviewed and the following MDS assessments were documented: a. An Admission MDS with an Assessment Reference Date (ARD) of 03/04/19; A Quarterly MDS with an ARD of 06/04/19; a Quarterly MDS with an ARD of 09/02/19; a Quarterly Q MDS with an ARD of 12/03/19; a Quarterly MDS with an ARD of 03/01/20; and a Quarterly MDS with an ARD of 06/01/20. A comprehensive assessment was due March 2020, however a Quarterly MDS was completed. 2. Resident #39 was admitted to the facility on [DATE], as documented on an Admission MDS with an ARD of 02/20/20. a. The Admission MDS with an ARD of 02/20/20, was not signed as completed until 05/26/20 by the Registered Nurse. This assessment was not completed in the regulatory time frame.
F 0637 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Assess the resident when there is a significant change in condition** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure a Significant Change Minimum Data Set (MDS) assessment was completed for 3 (Residents #7, #39 and #61) of 3 sampled residents who had a decline in 2 or more areas of Activities of Daily Living. This failed practice had the potential to affect 78 residents who resided in the facility based on the Resident Census and Condition of Residents provided by the Administrator on 07/06/20. The findings are: 1. Resident #7 had [DIAGNOSES REDACTED]. A Quarterly MDS with an Assessment Reference Date (ARD) of 06/09/20 documented the resident scored 9 (8-12 indicates moderately impaired) on a Brief Interview Mental Status (BIMS) and required total assistance for transfers, locomotion, toileting, and bathing; extensive assistance with dressing and personal hygiene; limited assistance with bed mobility; and did not walk. a. A record review and comparison of a 5-day MDS with an ARD of 12/25/19 with a quarterly MDS with an ARD of 06/09/20 documented the resident had a decline in transfers, walking, locomotion, dressing, eating, toilet use, personal hygiene, and bathing. A significant change MDS had not been done. b. On 07/10/20 at 11:15 A.M., the MDS Coordinator was asked if the resident should have had a significant change MDS based on a comparison of previous MDS. She stated, Yes, ma'am, more than one area of decline. She was asked when she would do a significant change MDS and she stated, When they have a significant decline or improvement, or on Hospice. 2. Resident #61 had [DIAGNOSES REDACTED]. A quarterly MDS with an ARD of 06/14/20 documented the resident scored 15 (13-15 indicates cognitively intact) on a BIMS and required extensive assistance for bed mobility, locomotion, eating, toileting, personal hygiene, dressing; total assistance with transferring and bathing; and did not walk. a. On 07/07/20 at 9:12 A.M., a comparison of the annual MDS with an ARD of 02/23/20 to the quarterly MDS with an ARD of 06/14/20 documented Resident #61 had a decline in transfers, eating, locomotion on and off the unit and in bathing. A significant change MDS had not been done. 3. Resident #37 had [DIAGNOSES REDACTED]. A Quarterly MDS with an ARD of 05/06/20 documented the resident scored 8 (8-12 indicates moderately impaired) on a BIMS, was totally dependent on two-plus persons physical assistance for bathing and required two-plus persons extensive assistance for dressing and personal hygiene. a. A comparison of the quarterly MDS with an ARD of 5/06/20 and the prior quarterly MDS with ARD of 2/4/20, revealed the resident had a decline in bed mobility where he changed from one to two-plus person assistance; changed from supervision to limited assistance with dressing and changed from one person to two-plus person physical assistance with toilet use. There was no Significant Change MDS completed for these changes. b. On 7/10/20 at 10:40 am, the MDS Coordinator was asked, When should you complete a Significant Change MDS? She stated, Goes to Hospice, significant decline in 2 or more ADLs (Activities of Daily Living). She was asked, If a resident has had a change in bed mobility, transfers and toilet use, whether it was a decline or improvement, does this meet the criteria to complete a significant change MDS? She stated, Yes.
F 0640 **Level of harm** - Potential for minimal harm **Residents Affected** - Some	**Encode each resident's assessment data and transmit these data to the State within 7 days of assessment.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure Minimum Data Set (MDS) discharge assessments were encoded and transmitted for residents who discharged to the hospital, home or other facility to ensure accuracy of information used for quality measures purposes for 2 (Resident #1 and #2) of 4 sampled residents who were discharged in the past six months. The failed practice had the potential to affect 55 residents who were discharged from the facility in the past six months, according to a list provided by the Director of Nursing on 07/10/20 at 12:53 p.m. The findings are: 1. Resident #1 was admitted to the facility on [DATE] as documented on an Admission MDS with an Assessment Reference Date (ARD) of 02/28/20. a. The Progress Notes documented, . 01/26/2020 10:04 (10:04 a.m.) Nsg (nursing)-Admission Summary . RECEIVED RESIDENT VIA (by way of) VAN DRIVER FROM (Facility Name) IN WHEELCHAIR . 02/26/2020 13:45 (1:45 p.m.) Nsg-Discharge Summary Note Text: Resident left building @ (at) 1340 (1:40 p.m.) with all belongings. Accompanied by his wife and son-in-law . b. On 07/09/20 at 4:57 p.m., the MDS section of the electronic clinical record for Resident #1 was reviewed and there was no discharge assessment completed at this time. 2. Resident #2 was admitted to the facility on [DATE] as documented on an Admission MDS with an ARD of 01/17/20. a. The Progress Notes documented, . 01/11/2020 17:59 (5:59 p.m.) Nsg - General Note . resident arrive at the facility at 1235 (12:35 p.m.) via wheelchair transported by (Company) . 03/20/2020 13:39 (1:39 p.m.) Nsg - Discharge Summary . Resident stable at this time . Staff assisted resident up to front of facility for discharge with family. b. On 07/09/20 at 4:57 p.m., the MDS section of the electronic clinical record for Resident #2 was reviewed and there was no discharge assessment completed at this time. 3. On 07/10/20 at 10:40 a.m., the MDS Coordinator was asked, When should a Discharge MDS assessment be completed? She stated, Within 7 days.
F 0641 **Level of harm** - Potential for minimal harm **Residents Affected** - Some	**Ensure each resident receives an accurate assessment.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interview, the facility failed to ensure Minimum Data Set (MDS) assessments were accurately completed for 2 (Residents #33 and 80) of 34 sampled residents who required MDS assessments and whose MDS

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F 0641 **Level of harm -** Potential for minimal harm **Residents Affected -** Some	(continued... from page 2) assessments were reviewed during the survey. The failed practice had the potential to affect all 78 residents who required MDS assessments according to the Resident Census and Condition of Residents dated 07/07/20 at 1:22 p.m. The findings are: 1. Resident #80 was admitted with a [DIAGNOSES REDACTED]. An Admission Minimum Date Set (MDS) with an Assessment Reference Date (ARD) of 03/01/20, required extensive two-plus person physical assistance for transfer, toilet use and bathing and required extensive one person physical assistance for bed mobility, dressing and personal hygiene and no impairment in functional limitation in range of motion in upper or lower extremities. a. The Progress Notes documented, 02/24/2020 17:45 (5:45 p.m.) Nsg (nursing) - General Note Text: report received from (Hospital) . right sided weakness,[MEDICAL CONDITION] IN Dec (December) . 02/26/2020 20:26 (8:26 p.m.) Nsg - Order Note Text: Physical Therapy required for skilled intervention 5-7 days per week for 8 weeks . focusing on thera (therapeutic) ex (exercise) , thera act (activities), neuromuscular re-educ (re-education), group therapy and gait training. b. An Order Summary Report documented, . Right Arm Rest And Right Leg Rest For WC (wheelchair) . Order Date 02/26/2020 . c. On 07/10/20 at 10:40 a.m., the MDS Coordinator was asked, If a resident is admitted with [MEDICAL CONDITION]/ (and/or) [MEDICAL CONDITION] that affects the (R) dominant side and the resident displays right sided weakness and [MEDICAL CONDITION], should this be coded on the MDS? She stated, Yes. She was asked, Why should the MDS be accurate? She stated, So we would know what care is needed and get star rating up, and billing correct and paint a picture of resident. 2. Resident #33 had [DIAGNOSES REDACTED]. A quarterly MDS documented the resident scored 3 (0-7 indicates severely impaired) on a Brief Interview Mental Status (BIMS). a. The resident's weights were documented as follows: On 01/03/20 her weight was 131 lbs. (pounds). On 02/10/20 her weight was 121 lbs. On 03/06/20 her weight was 120 lbs., and on 04/04/20 her weight was 113 lbs. This is a 7.82% weight loss in 3 months. b. The Minimum Data Set with an Assessment Reference Date of 05/02/20 documented No under weight loss more than 5%. c. On 7/10/20 at 11:15 a.m., the MDS Coordinator was asked if she would look at the resident's weights for the past 3 months. She was then asked to look at the MDS dated [DATE] for weight loss. She replied, Yes ma'am. It's more than 5%, oh yeah.
F 0657 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure a plan of care was revised to facilitate for 1 (Resident #37) of 34 sampled residents whose care plans were reviewed during this survey. This failed practice had the potential to affect 78 residents, as documented on the Resident Census and Condition of Residents dated 07/07/20 at 1:22 p.m. The findings are: Resident #37 had [DIAGNOSES REDACTED]. A Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 05/06/20 documented the resident scored 8 (8-12 indicates moderately impaired) on a Brief Interview for Mental Status (BIMS), was totally dependent on two-plus persons physical assistance for bathing and required two-plus persons extensive assistance for bed mobility, transfer, dressing, toilet use and personal hygiene. a. A Care Plan dated as completed 05/19/20, documented, . Focus . (Resident #37) has an alteration to his ADL (Activities of Daily Living) function d/t (due/to) weakness; incontinent episodes of B&B (bowel and bladder) secondary [MEDICAL CONDITION] . Interventions/(and/or) Tasks . (Resident #37) is extensive assistance with ADL's . Date Initiated: 08/02/2017 . Revision On: 08/09/2017 . (Resident 37) is total dependent upon staff x (times)1 with incontinent and peri care q (every) 2 hrs. (hours) and prn (as needed) . Revision On: 12/28/2017 . TRANSFER: (Resident #37) requires Mechanical Lift with (X2) (times 2) staff assistance for transfers . Date Initiated: 04/15/2020 . The care plan did not address the number of staff needed to assist resident for bed mobility, dressing or personal hygiene and documented only one staff to assist with incontinent and peri care. The MDS documented resident required two-plus persons physical assist with toilet use. b. On 07/10/20 at 10:40 a.m., the MDS Coordinator was asked, When do you update the resident's care plan? She stated, Quarterly and as needed. She was asked, If the resident has had either a decline or increase in ADLs and it reflected on the MDS, should the care plan be updated to reflect this change? She stated, Yes. She was asked, Why should the care plan be updated? She stated, So everyone taking care of resident would know how to care for the resident.
F 0661 **Level of harm -** Potential for minimal harm **Residents Affected -** Some	**Ensure necessary information is communicated to the resident, and receiving health care provider at the time of a planned discharge.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure a discharge summary documented a recapitulation of stay that consisted of a concise summary of the stay in the facility and course of treatment and a reconciliation pre and post admission medications, and discharge plans to provide necessary medical information for 1 (Resident #79) of 4 sampled residents who were discharged in the past 6 months, from [DATE] through [DATE]. This failed practice had the potential to affect 42 residents who were discharged from [DATE] through [DATE], as documented on a list provided by the Director of Nursing (DON) on [DATE] at 12:53 pm. The findings are: Resident #79 was admitted to the facility on [DATE] as documented on an Admission Minimum Data Set with an Assessment Reference Date of [DATE]. 1. The Progress Notes documented, . Effective Date: [DATE] 18:34 (6:34 p.m.) Type: Nsg (Nursing) - Admission Summary . Resident arrived via (by way of) (name) transportation . Alert and oriented x 2 (times 2). Some confusion of note. Resident chief [DIAGNOSES REDACTED]. 2. A Social Note dated [DATE] at 15:33 (3:33 p.m.) documented, . (Name) from (Facility) of (City) contacted me asking if we are providing transport for pt (patient) to their facility. Informed her we do not provide transport for discharging pts. Called (Name) (dtr) (daughter) and informed her she would have to pick r (resident) up and transport her to (Facility) of (City) . Dtr stated she would be here shortly . 3. A NSG/ (and/or) Provider Discharge Summary documented, . 1. Date of Discharge [DATE] . 3. Give a brief resident history Here for skilled services and medical management. 4. Give a brief summary of resident's stay Here for skilled services and medical management . Disposition of resident medications 6. Medications returned to Director of Nursing for proper disposal (dot) yes . There was no documented recapitulation of the resident's stay, a final summary of the resident's status or a reconciliation of all pre and post discharge medications for the resident documented on this form. 4. On [DATE] at 10:15 a.m., the Director of Nursing was asked, Who is responsible for completing the discharge summary? She stated, Discharging Nurse. She was asked, What are the necessary components that should be documented on the discharge summary? She stated, Medication, where they dispositioned to, follow up appointments, give family copy and go over everything with them. If expired, it's different. If AMA (against medical advice), it's different. If planned, it would be what I stated.
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 toenails were clean, trimmed, smooth, and free of jagged edges to promote good personal hygiene and grooming for 1 (Resident #24) of 32 sample residents who were dependent on staff for toenail care and failed to ensure fingernails were clean, trimmed, smooth, and free of jagged edges to promote good personal hygiene and grooming for 3 (Residents #24, #33 and #37) of 32 sample residents who were dependent on staff for nail care. These failed practices had the potential to affect 73 residents who were dependent on staff for toenail care and fingernail care, as documented on a list provided by the Director of Nursing (DON) on 07/10/20 at 12:53 pm. The findings are: 1. Resident #24 had a [DIAGNOSES REDACTED]. a. A Care Plan dated as completed 05/06/20, documented, . Focus . (Resident #24) has an ADL (Activities of Daily Living) self-care performance deficit r/t (related/to) Confusion, Impaired balance, Limited Mobility . Interventions/ (and/or) Tasks . (Resident #24) requires extensive assistance x 1 (times 1) staff with personal hygiene and oral care. . (Resident 24) has a potential for alteration in her skin r/t self-inflicted injury r/t resident grasping extremities and holding them in that position r/t involuntary movements and disease process . Interventions/Tasks . Avoid scratching and keep hands and body parts from excessive moisture. Keep fingernails short . Inservice staff that resident frequently grabs arms and knees r/t involuntary movements d/t (due/to) [MEDICAL CONDITION]'s disease . b. On 07/06/20 at 12:13 p.m., Resident #24 was asked if she would show this surveyor her

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F 0677 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 3) hand. She raised her left hand and her fingernails were greater than 1/4 inch in length and a dark substance was underneath the nail beds of some fingernails (Photo taken). c. On 07/06/20 at 6:17 p.m., Resident #24's Progress Notes were reviewed from 06/22/20 to 07/6/20 and there was no documentation that the resident had refused nail care. d. On 07/09/20 at 11:14 a.m., Certified Nursing Assistant (CNA) #3 and CNA #4 entered the resident's room to provide incontinent care. During incontinent care CNA #4 pulled the top sheet away from the resident's feet and the resident's toenails were greater than a 1/4 inch in length, extending past the tip of both of her great toes. The toenail of her right great toe was jagged and not smooth. Photo taken. e. On 07/09/30 at 11:35 a.m., CNA #3 was asked, When are her bath days? She stated, Monday, Wednesday, Friday. She was asked, Who is responsible for trimming and cleaning the resident's fingernails and toenails? She stated, If they are diabetic, the nurses and if not diabetic, the aides will. She was asked, Is she a diabetic? She stated, I don't know, but I can check with the nurse and find out. She was asked, When is nail care provided? She stated, On shower days or as needed. 2. Resident #37 had [DIAGNOSES REDACTED]. A Quarterly MDS with an ARD of 05/06/20 documented the resident scored 8 (8-12 indicates moderately impaired) on a BIMS, was totally dependent on two-plus persons physical assistance for bathing and required two-plus persons extensive assistance for dressing and personal hygiene. a. A Care Plan dated as completed 05/19/20, documented, . Focus . (Resident #37) has an alteration to his ADL function d/t weakness; incontinent episodes of B&B secondary [MEDICAL CONDITION]. Interventions/Tasks . (Resident #37) is extensive assistance with ADLs . Date Initiated: 08/02/2017 .TRANSFER: (Resident #37) requires Mechanical Lift with (X2) staff assistance for transfers . Date Initiated: 04/15/2020 . b. On 07/06/20 at 12:20 p.m., Resident #37 was sitting up in a wheelchair, awake, and the television was on in his room. This surveyor greeted the resident and while speaking with the resident noticed his fingernails were greater than 1/4 inch in length, had jagged edges and a dark brown substance was underneath the nail beds of some fingers. Photo taken. Resident #37 was asked, Does the staff trim your fingernails? He stated, My sister cuts them. He was asked, Since your sister has not been allowed to come in and visit, does the staff trim them for you? He moved his head in a left and right direction to indicate no. He was asked, Do they offer to do them for you? He stated, No. c. The resident's Progress Notes for June 1, 2020 to July 6, 2020 were reviewed and there was no documentation that the resident had refused nail care. d. On 07/10/20 at 10:15 a.m., the Director of Nursing (DON) was asked, Who is responsible for monitoring staff to ensure the resident's fingernails and toenails are trimmed, smooth and clean? She stated, The charge nurse. I'm responsible for special needs like residents refusing or podiatrist. 3. Resident #33 had [DIAGNOSES REDACTED]. A quarterly MDS documented the resident scored 3 (0-7 indicates severely impaired) on a BIMS and required extensive assistance with all ADLs except bathing where she required total assistance. a. A Care Plan updated on 12/26/19 documented, . Check nail length and trim and clean on bath days and as necessary . The resident requires supervision by one staff to eat . b. On 07/06/20 at 1:05 p.m., the resident was observed lying in bed with her lunch tray on an over the bed table across her lap. She was eating the mechanical soft porkchop with brown gravy with her fingers. Her fingernails were noted to have a dark brown substance under them. c. On 07/08/20 at 10:55 a.m., Resident #33's fingernails were observed to be approximately inch long, trimmed neatly and had a brown substance under all nails. d. On 07/09/20 at 11:26 a.m., Resident #33's fingernails were long and had a dark brown substance underneath them. e. On 7/10/20 at 11:55 a.m., the Director of Nursing was asked, Who is responsible for cleaning the resident's nails? She stated, The Charge Nurse, depending on the resident's diagnosis. Could be a nurse, CNA, or a podiatrist. She was asked, Could anyone clean a resident's nails, who would be able to do Resident 33's? She stated, She is care planned for behaviors, so they might do hers on any shift, whenever she would allow them to.
F 0687 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide appropriate foot care.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to ensure toenails were clean, trimmed, smooth, and free of jagged edges to promote good personal hygiene and grooming for 1 (Resident #74) of 4 (Residents #14,#15,#29 and #70) case mix residents who had [MEDICAL CONDITION] and dependent on staff for toenail care. This failed practice had the potential to affect 4 residents who were diabetic and dependent for toenail care according to a list provided by the Administrator on 07/09/20 at 5:39 P.M. The Finding are: 1. Resident #74 had [DIAGNOSES REDACTED]. The Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 06/22/20 documented the resident scored 3 (3 indicates severely impaired) on a Staff Assessment for Mental Status (SAMS) and was extensive assistance one person physical assist with hygiene. a. A Care Plan reviewed/ (and/or) revised on 05/19/20 documented, . BATHING/SHOWERING: Check nail length and trim and clean on bath day and as necessary. Report any changes to the nurse . c. On 07/06/2020 at 11:45 A.M., Resident #74 did not have on shoes or socks. His toenails on both the right and left foot were long, extending 1/8 to greater than 1/4 inches past the toenail tips. The nails were jagged and thick. d. On 07/06/2020 at 1:15 P.M., Resident #74's toenails on both the right and left foot were long, extending 1/8 to greater than 1/4 inches past the toenail tips. The nails were jagged and thick. e. On 07/09/20 at 2:50 P.M., the Administrator was asked, When is nail care done? She stated, The staff does the nail care on everyone and some residents see the podiatrist if they are diabetic or [MEDICAL CONDITION] for toenail care. She was asked, Does Resident #74 have [MEDICAL CONDITION] or is he a diabetic? She stated, He has [MEDICAL CONDITION]. She was asked, When was the Podiatrist at the facility for foot care? She stated, He was here right before we had to shut down for COVID-19. She was asked, Did the resident have his toenails trimmed at that time? She stated, He was admitted to the facility in February. I'm not sure that we've set him up for foot care. She was asked, Do you have a physician's orders [REDACTED].? She stated, You don't need an order to see the podiatrist. Their name is added to the podiatrist list. She was asked, Should a residents' toenails be trimmed, cut and cleaned in a timely manner? She stated, Yes.
F 0689 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.** Based on observation, record review and interview, the facility failed to ensure a resident's medication was not left on the overbed table in the resident's room for 1 (Resident #18) of 1 sample resident. This failed practice had the potential to affect all 77 residents who received medications based on a list of residents provided by Director of Nurses on 07/10/20. The findings are: a. On 07/06/20 at 11:22 a.m., Resident #18 was observed in bed with her over the bed table across her lap. There was a cup of medications on the table. She picked the cup up, put it down and stated, I don't want to take it, but I need it. A photo was taken of the medication in the cup. b. On 07/09/20 at 11:00 a.m., the Resident was asked about her medications that had been left on her table Monday (07/06/20). She stated, That's not my fault, that nurse just leaves them there and don't even wake me up. c. On 07/09/20 at 1:54 p.m., Registered Nurse #1 was asked if she ever left medications for the resident to take on their own. She stated, Most of them swallow and I make sure they swallow. Some think it's too early or want to wait for breakfast. I stand and make sure they take it. If they are not cognitive, I put it in their mouth and make sure they swallow it by checking their mouths. She was asked specifically about Resident #18. She stated, Yes, I give her her pill and I stay there till she swallows. She takes her pills; she sleeps a lot. She was shown the picture and she stated, Those look like her morning meds. d. On 07/10/20 at 11:55 a.m., the Director of Nursing was asked, Are asked if medications should be left in the resident's room. any residents assessed to self-medicate? She stated, No ma'am. She was then She of your stated, No ma'am.
F 0812 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Complaint # (AR 915) was substantiated, all or in part, with these findings: Based on observation and interview, the facility failed to ensure food items stored in a freezer were covered, sealed and dated, to prevent potential food borne illness for residents who received meals from 1 of 1 kitchen; ice scoop holder and ice machine were maintained in clean sanitary condition to prevent potential of bacteria growth and contamination for residents who received ice from 2 of 2 ice machines; expired food packages were promptly removed from stock and discarded to prevent potential of food borne illness for the residents who received meals from 1 of 1 kitchen; dietary staff washed their hands or changed gloves before

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	045455	A. BUILDING _____ B. WING _____	07/10/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
HICKORY HEIGHTS HEALTH AND REHAB, LLC	#3 CHENAL HEIGHTS DRIVE LITTLE ROCK, AR 72223

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F 0812 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	(continued... from page 4) handling clean equipment or food items to prevent potential food borne illness for residents who received meals from 1 of 1 kitchen and hot food items were maintained at or above a temperature of 135 degrees Fahrenheit (F) while awaiting the meal service, to prevent potential food borne illness for residents who received meals from 1 of 1 kitchen. These failed practices had the potential to affect 72 residents who received meals from the kitchen as documented on the Diet List provided by Dietary Supervisor on [DATE]. The findings are: 1. On [DATE] at 11:34 a.m., an initial tour of the kitchen was conducted with the Dietary Supervisor. At 11:42 a.m., the walk-in freezer had 2 bags of frozen sweet potato tots in a sealed, clear plastic bag, 1 bag of frozen sweet potato fries in a sealed, clear plastic bag, 2 frozen bags of Tomato Bisque in a sealed, clear plastic bag on a shelf and they were not dated. At 11:46 a.m., the reach in cooler had a clear plastic container with a white top with yellow liquid contents inside and it was sitting on the shelf. The Dietary Supervisor was asked to locate a date on the container, and she stated, It's not dated. At 11:58 a.m., the Dietary Supervisor was asked to check the ice machine with a paper towel and when she swiped the area where the ice comes out, there was a trace amount of a dark substance on the paper towel. Photo taken of the paper towel. 2. On [DATE] at 9:54 a.m., there were open boxes of bread sticks, chocolate chip cookies and pork fritters on a shelf in the walk-in freezer. The boxes were not covered or sealed. 3. On [DATE] at 10:01 a.m., the ice scoop holder attached on the left side of the ice machine had accumulation of corroded black slimy residue in it. The ice scoop was stored in the scoop holder and was in direct contact with the residue. The Dietary Supervisor was asked to wipe the residue at the bottom of the scoop holder. She did so, and the wet black substance easily transferred to the rag. She was asked, How often do you clean the ice scoop holder? She stated, We clean the scoop holder every week. There were black strips of residue on the right and the left side corners of the ice machine panel. It dripped on the ice and there were particles of black matter on top of the ice cubes. The Dietary Supervisor was asked to wipe the black residue on the panel inside the ice machine and on the corner. She did so, and the black-colored easily transferred to the rag. The Dietary Supervisor was asked, Who used the ice from the machine and how often do you clean the ice machine? She stated, We clean it once a week. That's the ice the CNAs (Certified Nursing Assistants) use for the water pitchers in the residents' rooms. The Dietary Supervisor was asked to describe the appearance of the ice scoop holder and the ice machine panel. She stated, The residue inside the ice scoop holder was black and slimy. The black strips of residue on the corner of the ice machine panel was grimy substance. On [DATE] at 10:21 a.m., the Assistant Dietary Supervisor was asked if the ice machine looked like it has been cleaned once a week. She stated, No. It was disgusting. It should be cleaned once a week. 4. On [DATE] at 10:31 a.m., the following observations were made in the storage room: a. 2 (20 Oz.) loaves of 100 % Whole Wheat bread were on a rack in the storage room. The label on the bags of bread documented an expiration date of [DATE]. b. 2 (16 Oz.) packages of crispy rounds tortilla chips on a rack in the storage room. The label on the bags documented, Use product by [DATE]. c. 2 (16 Oz.) packages of crispy rounds tortilla chips on a rack in the storage room. The label on the bags documented, Use product by [DATE]. d. 4 (16 Oz.) bags of Ruffles Potato Chips on a rack in the storage room. The label on the bags documented, Use product by [DATE]. e. On [DATE] at 10:49 a.m., an open 16 oz box of baking soda was on a shelf above the food preparation counter by the food preparation sink. 5. On [DATE] at 10:52 a.m., the bottom shelf of the deep fryer had an accumulation of greasy residue on it. The Dietary Supervisor was asked, How often do you clean it? The Assistant Dietary Supervisor stated, It's cleaned once a month. The Dietary Supervisor stated, It's cleaned every Thursday. The Dietary Supervisor was asked to describe the appearance of the deep fryer shelf. She stated, It looks like grease, caked up grease. 6. On [DATE] at11:04 a.m., Dietary Employee #1 picked up a box of saran wrap and placed it on the counter. Without changing gloves, she picked up clean plates to be used in portioning dessert and placed them on the counter with her fingers inside of them. 7. On [DATE] at 12:06 p.m., Dietary Employee #1 was wearing gloves when slicing buttermilk pie with a knife. She picked up 2 cartons of 2 % milk and placed them on the counter. At 12:09 p.m., without changing gloves and washing her hands, she picked up 3 servings of dinner rolls placed them into a blender, added 2 cartons of 2 % milk and pureed to be served to the residents on pureed diets. At 1:20 p.m., Dietary Employee #1 was asked, What did you do wrong when handling the dinner rolls? She stated, Yes, I touched it with my glove. When asked, What should you have done after touching dirty objects before handling clean equipment? She stated, Changed gloves and washed my hands. 8. On [DATE] at 12:11 p.m., the temperature of the food items on the steam table were checked by Dietary Employee #2 and registered as follows: a. Ground pulled pork - 118 degrees Fahrenheit. b. Pureed vegetables - 111 degrees Fahrenheit. c. Pureed pulled pork - 124 degrees Fahrenheit. d. Chicken noodle soup - 107 degrees Fahrenheit. 9. On [DATE] at 12:40 p.m., the above food items were not reheated before being served to the residents. 10. On [DATE] at 1:22 p.m., Dietary Employee #2 was asked when the food items are not hot enough what should you have done. She stated, I would reheat the mechanical meat or put it in the oven.
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, interview, and record review, the facility failed to ensure a syringe used for a gastrostomy (gastric) tube was changed every 24 hours and dated appropriately for 1 (Resident #7) of 3 (Residents #7, #24, and #45) sampled residents who had gastrostomy tubes. The facility failed to ensure signage was placed outside of the entry of a room that required the need for Personal Protective Equipment (PPE) for 1 (Resident 61) of 4 (Residents #61, #62, #76, and #228) sampled residents who were on isolation. These failed practices had the potential to affect 6 residents who had gastrostomy tubes per a list provided by Director of Nursing on 07/10/20 and 10 residents who were on isolation based on a list provided by the Administrator on 07/10/20. The findings are: 1. Resident #7 had a [DIAGNOSES REDACTED]. a. On 07/08/20 at 9:32 A.M., on initial rounds a syringe that was bagged and hanging on the feeding pump pole was dated 07/04/20. b. On 07/08/20 at 12:39 P.M., the bag with the syringe was dated 07/06/20. c. On 07/09/20 at 1:54 P.M., Registered Nurse #1 was asked who was responsible for changing the syringes used with the gastric tubes, and she stated, It depends. We change them every 24 hours. She was asked if she checked it during her shift, and she stated, Yes ma'am, I look at it, when I make rounds. She then stated, that Night shift usually changes them out and I do not work night shift. She was asked why it is important to change them every 24 hours and she stated, Moisture breeds bacteria. d. On 07/10/20 at 11:55 A.M., the Director of Nursing was asked when syringes used for gastric tube residents should be changed. She said, Supposed to be changed daily. The nurse on any shift, if you notice a syringe is not within the 24 hours, you would not use that syringe. 2. Resident #61 had [DIAGNOSES REDACTED]. A quarterly MDS with an ARD of 06/14/20 documented the resident scored 15 (13-15 indicates cognitively intact) on a BIMS and required extensive assistance with dressing, locomotion, eating, personal hygiene; total assistance for bathing, and transfers. a. On 07/06/20 at 11:36 A.M., Resident #61's room had no signage outside of the door that had red and yellow bags in boxes inside the room. Staff put on full PPE including N95 mask, gown, gloves and face shields prior to entering the room. b. On 07/06/20 at 12:08 P.M., CNA #2 was asked what kind of isolation the resident was in, and she stated, Precautionary, she's been out and came back. c. On 07/07/20 at 10:07 A.M., LPN #1 was asked about the type of isolation for the Resident #61's room and 2 other rooms on the hallway that did not have signage but supply carts outside their doors containing PPE. She stated, 14 days. These residents went out and came back to the facility. They are precaution. They will be in for 14 days. When asked what type of PPE is required, she stated, N95, gown, and gloves for isolation rooms. d. On 07/07/20 at 9:58 A.M., a sign on Residents #61's door read, Report to nurse before entering. e. On 07/10/20 at 10:00 A.M., the Director of Nursing was asked, Why is it important to have signage on the door of those residents in quarantine or isolation? She stated, To alert staff, (mobile) X Ray, (Laboratory company) to stop and go to the nurse's station before going in.
F 0921 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public.** Based on observation and interview, the facility failed to ensure the 100 hall side porch and the front parking lot remained free of debris in order to maintain a clean and home like environment. This failed practice had the potential to affect all 78 residents who resided in the facility, as documented on the Resident Census and Conditions of Residents dated 07/07/20 at 1:22 p.m. The findings are: 1.On 07/06/2020 at 1:00 p.m., many items were observed scattered on the 100 hall porch and lawn nearest the dining room area. There were 33 burnt cigarettes on the porch and several on the lawn. There were several plastic sleeves, used for crushing medication on the porch and lawn, and a Newport cigarette box lying on a

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F 0921 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 5) small table. 2. On 07/09/2020 at 6:00 a.m., many items were observed on the front facility parking lot. There were 3 blue gloves, a smashed Sprite can, a plastic can holder, pieces of scattered paper and plastic items, several different sizes of restaurant and convenient store cups, and a large amount of tinted broken green glass. 3. On 07/09/2020 at 2:50 p.m. the Administrator was asked, Should the 100 hall back porch and lawn remain free of debris and should the front parking lot remain free of scattered debris? She stated, Yes, the smokers use the plastic medical pouches to put cigarette ashes in. I have someone clean the parking lot on Monday mornings. By the time I get here in the morning the parking lot is full, that's probably why I don't see the items. Some staff put trash in the can near the door, if its full it falls over onto the ground. I will have to get someone to clean the parking lot more frequently. She stated, Yes, they both should remain free of debris.