STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045401	A. BUILDING _____ B. WING _____	**08/27/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
WHITE RIVER HEALTHCARE	**1569 AR HIGHWAY 56 CALICO ROCK, AR 72519**

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 0580 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Complaint (AR 855) was substantiated, all or in part, with these findings: Based on observations, interview and record review, the facility failed to ensure the Power of Attorney (POA) was promptly notified after a fall with injury for 1 (Resident #1) of 1 resident who had a fall and obtained an injury. Resident #1 had [DIAGNOSES REDACTED]. The Significant Change Minimum Data Set with an Assessment Reference Date of [DATE] documented the resident was severely impaired in cognitive skills per a Staff Assessment for Mental Status, required extensive physical assist of 2 persons for bed mobility, transfer, dressing, and toilet use, required extensive physical assist of 1 person for eating and personal hygiene, and was always incontinent of bowel and bladder, and was under the care of Hospice Services. a. Resident #1's Face Sheet documented: (Resident #1) admitted to the facility on [DATE] and was own Responsible Party with (Complainant) being the POA (Power of Attorney) - Care Conference Person. b. A care plan with an initiated date of [DATE] documented, .Inform the resident/family/caregivers of any new area of skin breakdown . c. A physician order [REDACTED].Remove sutures to left eyebrow in 7 days . d. A physician order [REDACTED].Clean sutures to left eyebrow with wound cleanser, pat dry. Apply TAO (Triple Antibiotic Ointment) q (every) day and PRN (as needed), leave open to air until healed . e. A progress note dated [DATE] at 1:07 a.m. documented, . NSG (Nursing) - I/A (Incident /Accident) Note .Incident Description . resident was lying on floor .nurse entered room, resident lying on left side. Blood noted to left eye and left arm. Resident left eye cleaned with wound cleanser unable to stop bleeding with gash noted. Skin tear to left arm cleaned. Resident c/o (complains of) pain to left leg, bruise noted to leg and left shoulder .Immediate Intervention: Resident was cleaned. (Ambulance) notified . There was no documentation the POA was notified. f. A progress note dated [DATE] at 2:45 a.m. documented, . resident return to facility via transport van at approx (approximately) 0200 (2:00 a.m.). Resident has Laceration to left eye approx 2cm (centimeters), 2 stitches applied. Contusions with ecchymosis to left shoulder, left knee, and left hip. 2 skin tears to left elbow. Resident resting in bed . The POA was not notified. There was no documentation the POA was notified. g. A progress note dated [DATE] at 12:00 p.m. documented, . Nsg- I/A Follow Up .Date and I&A (Incident and Accident) Description: [DATE] 00:00 (12:00 a.m.) Resident rolled out of bed . Long Term Intervention: Keep bed in lowest position and place fall mat at bedside .Added to the Care Plan: Yes . Ensure MD (Medical Doctor) & Family Notification: Yes . The POA was notified of Resident #1's injury three days after the injury. There was no documentation the POA was notified. h. On [DATE] at 2:15 p.m., The POA was asked, Were you (Resident #1's) POA. The POA replied, Well if you read her paperwork, I was everything. The POA was asked, Did you provide that information/paperwork to the facility? The POA replied, Yes. The POA was asked, When did (Resident #1) fall out of bed? The POA replied, The week she passed away. So they called 2 to 3 days later to tell me she had fallen, and they didn't think it was an emergency, but she had stitches above her left eye. I didn't get a chance to see her and I am not sure how many she had. The POA was asked, Who called and told you about the fall? The POA replied, It was the Social Service Director (SSD) that called and told me they didn't call me because they didn't want to wake me. i. On [DATE] at 10:29 a.m., the SSD was asked for a copy of Power of Attorney papers for (Resident #1). At 10:35 a.m. the SSD stated, I don't think they have one. The SSD was asked, Was the (POA) the Power of Attorney for (Resident #1)? The SSD replied, The (POA) was the POA, but she didn't bring the paperwork to us. The SSD was asked, If anything happens to the resident, do you call the POA? The SSD replied, Yes, (Resident #1) didn't have family when she came to us before Christmas, and then the Power of Attorney's husband died , and she was all that the resident had. j. On [DATE] at 11:37 a.m., The SSD was asked, How do you know who the Power of Attorney for a resident is? The SSD replied, When they come in and they have Power of Attorney paperwork. The SSD was asked, If a resident has a change of condition, who do you notify? The SSD replied, The Power of Attorney. k. On [DATE] at 9:39 a.m., Licensed Practical Nurse (LPN) #1 was asked, How do you know who the Power of Attorney for a resident is? LPN #1 replied, Go to the face sheet, profile page. LPN #1 was asked, If a resident has a change of condition, who do you notify? LPN #1 replied, The doctor, family, Power of Attorney, or responsible party or emergency contact if I can't get a hold of Power of Attorney or responsible party. LPN #1 was asked, Can you look and tell me, if (Resident #1's) Power of Attorney was notified on [DATE] when (Resident #1) fell out of bed? LPN #1 replied, On [DATE], no notification. l. On [DATE] at 10:08 a.m., Registered Nurse (RN) #1 was asked, How do you know who the Power of Attorney is on the resident's profile? RN #1 replied, They bring in the paperwork that indicates it and the documentation is scanned into Point Click Care under miscellaneous. RN #1 was asked, What if it's not there? RN #1 replied, It would be in the Business Office, we have hard copies. RN #1 was asked, If a resident has a change of condition, who do you notify? RN #1 replied, The physician and family or Power of Attorney. RN #1 was asked, Was (Resident #1's) Power of Attorney notified on [DATE] when (Resident #1's) fell out of bed and was sent to the hospital? RN #1 reviewed the I & A dated [DATE] and stated, Not on [DATE] but on [DATE]. m. On [DATE] at 12:31 p.m., the Administrator was asked, Should the Power of Attorney be notified if a resident has a change of condition? The Administrator replied, Absolutely. n. The Resident Rights documented, .Have your representative notified .the nursing home must notify your doctor and if known, your legal representative or an interested family member when the following occurs .you're involved in an accident and are injured and/or need to see a doctor .
F 0584 **Level of harm -** Potential for minimal harm **Residents Affected -** Many	**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, interview, and record review, the facility failed to ensure used latex/(and or) vinyl gloves and pillows were off the floor, urinals and bedpans were clean, rooms were free of odors, and used briefs were disposed of properly to provide a clean, orderly and sanitary environment. These failed practices had the potential to affect 53 residents according to the Roster Matrix provided by the Administrator on 08/24/2020. The findings are: 1. On 08/24/2020 at 10:08 a.m., a used disposable bed pad/chux was on the bed in Resident room [ROOM NUMBER]. The bed pad was at the end of the bed, between the bed and against the wall. (Photo taken.) On 08/24/2020 at 10:10 a.m., Certified Nursing Assistant (CNA) #1 was asked, What is that on the bed, and up against the wall? CNA #1 replied, it's a chux. CNA #1 was asked, Is it clean? CNA #1 replied, I'm not sure, it's not wet, but I'll get rid of it. 2. On 08/24/2020 at 10:12 a.m., Resident room [ROOM NUMBER] had a pungent urine odor. A urinal with small amount of brownish/yellowish liquid inside was hanging on the rail. (Photo taken.) 3. On 08/24/2020 at 10:15 a.m., in Resident room [ROOM NUMBER], a urinal with small amount of brownish/yellowish liquid inside was on the bedrail. (Photo taken.) 4.On 08/24/2020 at 10:18 a.m., in Resident room [ROOM NUMBER], a urinal was on the resident's bedside table next to food and drinks. (Photo taken.) 5. On 08/24/2020 at 10:20

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 0584 **Level of harm** - Potential for minimal harm **Residents Affected** - Many	(continued... from page 1) a.m., in Resident room [ROOM NUMBER], a urinal with small amount of brownish/yellowish liquid inside and a 60cc (cubic centimeter) piston syringe was in the bathroom. (Photo taken.) 6. On 08/24/2020 at 10:22 a.m., in Resident room [ROOM NUMBER], a urinal with small amount of brownish/yellowish liquid inside was on rail of the resident's bed. An unlabeled urinal with small amount of brownish/yellowish liquid inside was in the bathroom. 7. On 08/24/2020 at 10:26 a.m., in Resident room [ROOM NUMBER], a pair of used blue gloves were in the bathroom floor. (Photo taken.) 8. On 08/24/2020 at 10:38 a.m., in Resident room [ROOM NUMBER], a urinal with small amount of brownish/yellowish liquid inside was in the bathroom. (Photo taken.) 9. On 08/24/2020 at 10:37 a.m., in Resident room [ROOM NUMBER], a bed pan was in a wash basin in the bathroom floor. (Photo taken.) 10. On 08/24/2020 at 10:41 a.m., in Resident room [ROOM NUMBER], a pillow was in the floor. A urinal with small amount of brownish/yellowish liquid inside was in the bathroom. (Photo taken.) 11. On 08/24/2020 at 10:44 a.m., in Resident room [ROOM NUMBER], a urinal with small amount of brownish/yellowish liquid inside was on the bed rail. A set of clean linens were observed at the head of the bed, approximately 1 foot from the urinal. (Photo taken.) 12. On 08/25/2020 at 12:06 a.m., Licensed Practical Nurse (LPN) #1 was asked, How are used chuk/bed pads stored? LPN #1 replied, In a trash bag and taken out. LPN #1 was asked, Should they be left on the bed and against the wall? LPN #1 replied, No. LPN #1 was asked, Would that be considered an infection control issue? LPN #1 replied, Yes, I would think so. LPN #1 was asked, How are resident's urinals and bed pans supposed to be stored when not in use? LPN #1 replied, In the bathroom, should be labeled, not in the washbasin. LPN #1 was asked, Would storing the urinals and bed pans on bed rails, bedside tables, and in wash basins, and unlabeled be considered an infection control issue? LPN #1 replied, Yes. LPN #1 was asked, How are used briefs and gloves disposed of? LPN #1 replied, In a trash bag, taken out immediately. LPN #1 was asked, Should the briefs be left in the trash cans in the resident room, and used gloves be in the floor? LPN #1 replied, No. LPN #1 was asked, Would that be considered an infection control issue? LPN #1 replied, Yes. LPN #1 was asked, Should a resident's pillow be on the floor? LPN #1 replied, No. LPN #1 was asked, Would this be considered an infection control issue? LPN #1 replied, Yes. 13.On 08/25/2020 at 12:54 p.m., Certified Nursing Assistant (CNA) #2 was asked, How are used chux/bed pads stored? CNA #2 replied, In the trash. CNA #2 was asked, Should they be left on the bed and against the wall? CNA #2 replied, No. CNA #2 was asked, Would that be considered an infection control issue? CNA #2 replied, Yes. CNA #2 was asked, How are resident's urinals and bed pans supposed to be stored when not in use? CNA #2 replied, In a bag, dated, with a name. CNA #2 was asked, Would storing the urinals and bed pans on bed rails, bedside tables, and in wash basins, and unlabeled be considered an infection control issue? CNA #2 replied, Yes. CNA #2 was asked, How are used briefs and gloves disposed of? CNA #2 replied, In the trash, take the trash from the resident's room, and place in the big trash in the hall. CNA #2 was asked, Should the briefs be left in the trash cans in the resident's room, and gloves be in the floor? CNA #2 replied, No. CNA #2 was asked, Would this be considered an infection control issue? CNA #2 replied, Yes. CNA #2 was asked, Should a resident's pillow be on the floor? CNA #2 replied, No. CNA #2 was asked, Would this be considered an infection control issue? CNA #2 replied, Yes. 14.On 08/25/2020 at 1:06 p.m., Registered Nurse (RN) #1 was asked, How are used chuck/bed pads stored? RN #1 replied, Throw them away. RN #1 was asked, Should they be left on the bed and against the wall? RN #1 replied, No. RN #1 was asked, Would this be considered an infection control issue? RN #1 replied, Yes. RN #1 was asked, How are residents' urinals and bed pans supposed to be stored when not in use? RN #1 replied, On their rail or in the bathroom with a date on them. RN #1 was asked, Would storing the urinals and bed pans on bed rails, bedside tables, and in wash basins, and unlabeled be considered an infection control issue? RN #1 replied, Yes. RN #1 was asked, How are used briefs and gloves disposed of? RN #1 replied, Taken out. RN #1 was asked, Should the briefs be left in the trash cans in the resident room, and gloves be in the floor? RN #1 replied, No. RN #1 was asked, Would this be considered an infection control issue? RN #1 replied, Yes. RN #1 was asked, Should a resident's pillows be on the floor? RN #1 replied, No. RN #1 was asked, Would that be considered an infection control issue? RN #1 replied, Yes. 15. On 08/25/2020 at 1:16 p.m., The Administrator was asked, How are used chuck/bed pads stored? The Administrator replied, Thrown away. The Administrator was asked, Should they be left on the bed and against the wall? The Administrator replied, No. The Administrator was asked, Would this be considered an infection control issue? The Administrator replied, Yes. The Administrator was asked, How are resident's urinals and bed pans supposed to be stored when not in use? The Administrator replied, In a bag and stored in the cabinet. The Administrator was asked, Do you mean, in a bag and stored in the resident's bedside table? The Administrator replied, Yes, if they still have them. The Administrator was asked, How are used briefs and gloves disposed of? The Administrator replied, Taken out of the resident room. The Administrator was asked, Should the briefs be left in the trash cans in the resident room, and gloves be in the floor? The Administrator replied, No. The Administrator was asked, Would this be considered an infection control issue? The Administrator replied, Yes. The Administrator was asked, Should a resident's pillows be on the floor? The Administrator replied, No. The Administrator was asked, Would this be considered an infection control issue? The Administrator replied, It could be. 16. The Cleaning and Disinfecting Non-Critical Resident-Care Items Policy provided by the Assistant Director of Nursing on 08/26/2020documented, .The purpose of this procedure is to provide guidelines for disinfection of non-critical resident-care items Single resident-use items are cleaned/disinfected between uses by a single resident and disposed of afterwards (e.g. bedpans, urinals) .Rinse bedpan or urinal with cool water to remove feces and urine .Wash surface of bedpan or urinal with disinfectant solution .Place article on paper towel and allow to air dry or dry article with paper towel .return the bedpan or urinal to resident's bedside cabinet . 17. The Diaper / Underpads Policy provided by the Assistant Director of Nursing on 08/26/2020 documented, .The purpose of this procedure is to provide guidelines for the proper handling of diapers and under pads. .Place diaper or under pad into designated hamper/container. .Discard disposable equipment into designated hamper/container. .Remove gloves and discard into designated container .
F 0690 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interview, the facility failed to ensure urinary catheter drainage bags did not come into contact with the floor to prevent contamination. This failed practice had the potential to affect 3 residents residing in the facility who had indwelling catheters, as documented on the Resident Census and Conditions of Residents provided by the Director of Nursing on 08/24/2020. The findings are: 1. On 08/24/2020 at 10:12 a.m., in Resident room [ROOM NUMBER] the resident's urinary catheter bag was on the floor. (Photo taken.) 2. On 08/24/2020 at 10:20 a.m., in Resident room [ROOM NUMBER], a catheter bag was on the floor next to the bed. (Photo taken.) 3. On 08/25/2020 at 12:06 a.m., Licensed Practical Nurse (LPN) #1 was asked, Should urinary catheter bags be on the floor? LPN #1 replied, Absolutely not. LPN #1 was asked, Would that be considered an infection control issue? LPN #1 replied, Absolutely. 4. On 08/25/2020 at 12:54 p.m., Certified Nursing Assistant (CNA) #2 was asked, Should urinary catheter bags be on the floor? CNA #2 replied, No. CNA #2 was asked, Would this be considered an infection control issue? CNA #2 replied, Yes. 5. On 08/25/2020 at 1:06 p.m., Registered Nurse (RN) #1 was asked, Should urinary catheter bags be on the floor? RN #1 replied, No. RN #1 was asked, Would this be considered an infection control issue? RN #1 replied, Yes. 6. On 08/25/2020 at 1:16 p.m., The Administrator was asked, Should urinary catheter bags be on the floor? The Administrator replied, No. The Administrator was asked, Would this be considered an infection control issue? The Administrator replied, It could be. 7. The Urinary Tract Infections (Catheter-Associated), Guidelines for Preventing policy provided by the Assistant Director of Nursing on 08/26/2020 documented, .The purpose of this procedure is to provide guidelines for the prevention of catheter-associated urinary tract infections .Do not place the drainage bag on the floor .
F 0693 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure percutaneous endoscopic gastrostomy (PEG) tubing was capped and bags were labeled and or disposed of when not in use to prevent the potential for contamination. This failed practice had the potential to affect 5 residents who received tube feeding as documented on the Resident Census and Conditions of Residents provided by the Director of Nursing on 08/24/2020. The findings are: 1. On 08/24/2020 at 10:41 a.m., in Resident room [ROOM NUMBER], a clear bag of brown liquid, attached to an Intravenous Pole and feeding pump, was

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F 0693 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 2) not labeled or dated, the spike adapter was not capped and left out in the open. (Photo taken.) 2. On 08/25/2020 at 12:06 a.m., Licensed Practical Nurse (LPN) #1 was asked, How should the tube feeding tubing be stored when not in use?. LPN #1 replied, In a bag. LPN #1 was asked, Should it be capped? LPN #1 replied, yes. LPN #1 was asked, Would not capping the tubing, leaving the tubing out in the open, not dated, or the bag not being labeled, be considered an infection control issue? LPN #1 replied, Yes. 3. On 08/25/2020 at 1:06 p.m., Registered Nurse (RN) #1 was asked, How should the tube feeding tubing be stored when not in use? RN #1 was shown pictures of a clear, unlabeled bag and tubing, containing brown liquid, hanging on an IV pole, and uncapped. RN #1 replied, That should have been taken down and thrown away. RN #1 was asked, Would that be considered an infection control issue? RN #1 replied, Yes. 4. On 08/25/2020 at 1:16 p.m., The Administrator was asked, How should the tube feeding tubing be stored when not in use? The Administrator was shown pictures of a clear, unlabeled bag and tubing, containing brown liquid, hanging on an IV pole, and uncapped. The Administrator was asked, Would this be considered an infection control issue? The Administrator replied, Yes, yes, it could be.
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 nebulizer tubing and mouthpiece equipment were stored when not in use and oxygen tubing and humidifier bottles were stored when not in use and or labeled when not in use to prevent potential contamination or infection. This failed practice had the potential to affect 9 residents who received respiratory treatments as documented on the Resident Census and Conditions of Residents provided by the Director of Nursing on 08/24/2020. The findings are: 1. On 08/24/2020 at 10:15 a.m., in Resident room [ROOM NUMBER], a nebulizer mask and tubing and a half full humidifier bottle were on the dresser. The nebulizer mask and tubing were not stored. (Photo taken.) 2. On 08/24/2020 at 10:41 a.m., in Resident room [ROOM NUMBER], a nebulizer mask and tubing were on the bedside table, not stored in a container. The Oxygen was on the resident and running at 2 liters a minute via (by way of) nasal cannula. The oxygen tubing was not dated, the humidifier bottle was not dated and empty. (Photo taken.) 3. On 08/24/2020 at 10:44 a.m., in Resident room [ROOM NUMBER], an oxygen concentrator with nasal cannula tubing and a humidifier bottle attached was not labeled or stored in a container. (Photo taken.) 4. On 08/25/2020 at 12:06 a.m., Licensed Practical Nurse (LPN) #1 was asked, How is nebulizer tubing and oxygen tubing stored when not in use? LPN #1 replied, In a bag, with name, date, and the nurse signature. LPN #1 was asked, Would leaving the nebulizer mask and tubing and oxygen tubing out in the open, be considered an infection control issue? LPN #1 replied, Yes. 5. On 08/25/2020 at 12:54 p.m., Certified Nursing Assistant (CNA) #2 was asked, How is nebulizer tubing and oxygen tubing stored when not in use? CNA #2 replied, In a bag and labeled. CNA #2 was asked, Would leaving the nebulizer mask and tubing and oxygen tubing out in the open, be considered an infection control issue? CNA #2 replied, Yes. 6. On 08/25/2020 at 1:06 p.m., Registered Nurse (RN) #1 was asked, How is nebulizer tubing and oxygen tubing stored when not in use? RN #1 replied, In a bag. RN #1 was asked, Would leaving the nebulizer mask and tubing and oxygen tubing out in the open, be considered an infection control issue? RN #1 replied, Yes. 7. On 08/25/2020 at 1:16 p.m., The Administrator was asked, How is nebulizer tubing and oxygen tubing stored when not in use? The Administrator replied, In a bag. The Administrator was asked, Would leaving the nebulizer mask and tubing and oxygen tubing out in the open, be considered an infection control issue? The Administrator replied, It could be. 8. The Oxygen Administration Policy provided by the Registered Nurse #1 on 08/25/2020 documented, .The purpose of this procedure is to provide guidelines for safe oxygen administration .Steps in the Procedure .discard used supplies into designated containers . 9. The Administering Medications through a Small Volume (Handheld) Nebulizer Policy provided by the Assistant Director of Nursing on 08/26/2020 documented, .The purpose of this procedure is to safely and aseptically administer aerosolized particles of medication into the resident's airway .Rinse and disinfect the nebulizer equipment according to facility protocol .when equipment is completely dry, store in a plastic bag with the resident's name and the date on it .