STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045459	A. BUILDING _____ B. WING _____	06/04/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
HAPPY VALLEY NURSING & REHABILITATION	**955 DIVISION STREET MALVERN, AR 72104**

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 0880 **Level of harm -** Immediate jeopardy **Residents Affected -** Many	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Complaint # (AR 727) was substantiated, all or in part, with these findings. Complaint # (AR 890) was substantiated, all or in part, with these findings. A. Based on observation, record review, and interview, the facility failed to ensure proper infection prevention and control practices were consistently maintained to prevent the development and transmission of COVID-19 and other communicable diseases as evidenced by failure to ensure all personnel were adequately trained in the use of Personal Protective Equipment (PPE), to wear a face mask at all times and to encourage residents to wear face masks upon leaving and returning to facility; failed to ensure employees were consistently screened for COVID-19 upon entering the building; failed to ensure the facility had and implemented a current Policy and Procedure for COVID-19 for 5 (Residents (R) #1, #2, #3, #4, and #6) of 6 (Residents #1- #6) sampled residents and staff to prevent the potential spread of COVID-19 and other infectious diseases. These failed practices resulted in Immediate Jeopardy, which caused or could have caused serious harm, injury, or death to the 41 residents who resided in the facility. The Administrator was informed of the Immediate Jeopardy condition on 6/1/2020 at 2:41 PM. The findings are: 1. On 6/1/2020 at 9:28 a.m., surveyors knocked on the front door, Licensed Practical Nurse (LPN) #1 greeted us without a mask on, took our temperatures, asked no screening questions, then directed us to the conference room. At 9:35 a.m., Certified Nursing Assistant (CNA) #1 was at the nurse's station with no mask on, at 9:36 a.m., Laundry Worker #1 was at the nurse's station with no mask on, at 9:38 a.m., LPN #2 was in an office with no mask on, and CNA #2 walked out of the shower room on the 400 hall with no mask on. At 10:45 a.m., the Administrator was asked where the PPE equipment was stored and stated, we have some in my office, some in the business office, the medication room and a storage room. At 11:00 a.m., a review of the Administrator's office identified a case of gloves, and the medication room with LPN #1 had no PPE. The Activity Director/CNA was asked where the masks were and stated, I don't know. LPN #1 said I have some at the nurse's station. At the nurse's station 1 package of masks were available. The BOM was asked if he had more masks, and stated, No, I can't remember if I ordered them or not. He was asked to provide an invoice of the order. 2. Resident #1 was admitted on [DATE] with a [DIAGNOSES REDACTED]. a. The physician orders [REDACTED]. b. The Care Plan dated 4/6/2020 documented, [MEDICAL TREATMENT]-[MEDICAL CONDITION] . Potential for complications related to [MEDICAL TREATMENT] for [DIAGNOSES REDACTED].Chronic. The Care Plan did not document a risk for COVID-19 due to [MEDICAL TREATMENT] nor the need for a mask. c. On 6/1/2020 at 10:15 AM, Resident #1 was not in his room. CNA #5 was asked, Do you know where R #1 might be? She stated, [MEDICAL TREATMENT]. They all go on Monday, Wednesday and Friday. d. On 6/1/2020 at 10:31 AM, record review of the residents Medication Administration Review (MAR) showed no documentation the facility conducted COVID-19 screening for the resident. e. On 6/2/2020 at 12:24 PM, called ([MEDICAL TREATMENT] Center) and asked the Administrator, Does the resident wear a mask when they are transported to and from your building? She stated, No, he doesn't. We give masks to everyone and do the COVID-19 screening every time they come. When asked, Do you know why the resident is coming for [MEDICAL TREATMENT] on Monday- Wednesday- Friday when his physician order [REDACTED].? She stated, When he started here, he was Tuesday-Thursday- Saturday, but there was a change in his order, and it is now Monday- Wednesday- Friday. 3. Resident #2 had [DIAGNOSES REDACTED]. a. The Care Plan updated on 4/22/2020 did not document a risk for COVID-19 due to [MEDICAL TREATMENT] or re-hospitalization and did not document a mask was recommended when going to [MEDICAL TREATMENT]. b. The May 2020 Physician orders [REDACTED]. c. The nurse notes dated 5/11/2020 documented, .6-2 resident oxygen saturation at 84% on 4 liters of oxygen, called ambulance picked up resident at 1330 (1:30 p.m.) transported to hospital at resident request. On 5/13/2020 nurse notes documented. .6a-2p returned to facility from hospital. There was no documentation of a respiratory assessment done upon return to the facility. 4. Resident #3 had [DIAGNOSES REDACTED]. a. The May 2020 physician orders [REDACTED]. b. The Care Plan initiated 5/3/2020 did not document a risk for COVID-19 due to [MEDICAL TREATMENT] or re-hospitalization it did not document a mask was recommended when going to [MEDICAL TREATMENT]. 5. Resident #4 was admitted [DATE] with [DIAGNOSES REDACTED]. A review of the admission care plan did not document a risk for COVID-19 due to recent hospitalization . 6. Resident #6 had [DIAGNOSES REDACTED]. a. The June 2020 MAR indicated [REDACTED]. b. The Care Plan dated 3/18/20 did not address COVID-19 with resident's transfer back to the facility from the hospital on [DATE]. c. On 6/03/20 at 07:34 AM, a record review of the May 2020 resident daily temperature monitoring log (which listed all the residents) documented no resident's temperature screenings on 5/7/20 and 5/8/20 for the 6:00 a.m. to the 2:00 p.m. (6-2) shift. There were no resident temperature screenings for 5/18/20 and 5/19/20 for the 6-2 shift and the 2:00 p.m. to 10:00 p.m. shift. There were no resident temperature screenings for 5/25/20, 5/26/20 and 5/27/20 for the 6-2 shift. 7. On 6/1/2020 at 9:33 AM, LPN #2 was on the 100 hallway, passing resident medications without a mask on. LPN #2 was asked Should you be wearing a mask? She stated, Yes, ma'am. 8. On 6/1/2020 at 9:55 AM, CNA #4 was in the hallway without a mask on. When asked, Should you have on a mask? He stated, Yes. When asked, Where do you get your PPE from? He stated, From the nurses. 9. On 6/1/2020 at 10:04 AM, CNA #5 was passing ice down the 100 hallways without a mask on. When asked, Should you be wearing a mask? She stated, Yes. Forgot mine at home this morning. When asked, Does the facility have PPE for you to wear? She stated, We normally do, I just don't know where they are right now. When asked, Have you ever run out of PPE? She stated, Yes, masks. 10. On 6/1/2020 at 10:10 AM, the Director of Nursing (DON) was asked for the infection control tracking and trending for the past 3 months. At 1:25 p.m., the DON stated, I couldn't locate it, I called the Infection Prevention Nurse Licensed Practical Nurse (LPN) #3 who left a couple of weeks ago and asked her for the tracking/trending information and she stated, 'I didn't do it' and hung up on me. 11. On 6/1/2020 at 10:19 AM, a CNA and LPN #1 was observed pulling masks below their nose and mouth. LPN #1 was talking on the telephone with her mask below her nose and mouth while sitting at the nurse's station 12. On 6/01/20 at 10:21 a.m., LPN #1 at nurse's station, was pulling mask down off of nose and mouth and stated, I have a real hard time breathing in this, I'm just not use to it. On 6/01/20 at 10:24 a.m., observed CNA's and LPN's with no masks on, or if mask is on it is being pulled down below the nose and mouth. 13. On 6/1/2020 at 10:30 AM, a non-sampled resident was asked, Do you see staff on the evening and night shift with a mask on? The resident stated, Some do, and some don't. 14. On 6/1/2020 at 10:45 AM, the Administrator was asked why the screening process wasn't completed as to screening questions and assessment of illness? She stated, I guess we've been more relaxed than we should have been without any COVID-19. 15. On 6/1/2020 at 10:58 AM, CNA #4 was asked, Do you run out of gloves often? She stated, Sometimes. At 11:50 a.m., CNA #4 was observed with his mask pulled down below his nose and mouth. At 11:05 AM, CNA #3 was asked, Where is the PPE equipment kept? She stated, The what? Surveyor clarified the isolation equipment. She stated, Oh that's maintenance's responsibility. At 12:15 PM, CNA #1 was asked, Has the facility staff been in-serviced on education related to COVID-19? Stated, I can't recall when, but I think so. 16. On 6/1/2020 at 12:35 PM, LPN #1 was asked, Are you the designated screener? Stated, Well I do it cause I'm at the nurse's station. She was asked to provide the screening tool used by the facility. What was provided was a Visitor Screening Tool that documented, .fever of 100.4 degrees within the last 14 days, cough/shortness of breath, pneumonia/flu - recent, have you traveled out of the country in the last 14 days to a level 2 or 3 country as determined by the Centers for Disease Control and Prevention, have you had contact with anyone who has lab confirmed Novel Coronavirus within 14 days of symptom onset with a

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 0880 **Level of harm -** Immediate jeopardy **Residents Affected -** Many	(continued... from page 1) temperature line and staff signature, The facility staff only had temperature checks. LPN #1 was asked why staff were not asked the screening questions, and stated, We're supposed to do screening on all employees every time they come in? The surveyor replied, Yes. At 1:22 PM, Housekeeper #1 was asked, When did you start (working)? Housekeeper #1 stated, Today's my first day. Were you trained on COVID-19? Housekeeper #1 stated, Not really, just that we have to wear a mask. When did you put your mask on today? Housekeeper #1 stated, I put it on right after I saw you. At 1:42 PM, CNA #3 was asked, Do the resident's leaving for [MEDICAL TREATMENT] have masks on when leaving? CNA #3 stated, No ma'am, they often refuse it. At 1:55 PM, the DON was observed behind the nurse's station with no mask on. At 2:36 PM, a non-sampled resident was asked, Do staff wear their masks at all times on all shifts? She stated, No. 17. On 6/2/2020 at 8:49 AM, LPN #1 was asked, Are their assigned screeners on the evening, night shifts and on the weekends? She stated, I don't think so, I stay here as late as I can. 18. The Centers for Disease Control (CDC) guidelines for COVID-19 Preparedness Checklist for Nursing Homes and other Long-Term Care Settings found at https://www.cdc.gov/coronavirus/2019-ncov/healthcare-facilities/prevent-spread-in-long-term-care-facilities.html, documented, .Things facilities should do now: Educate Residents, Healthcare Personnel, and Visitors . Educate and train HCP (healthcare personnel) . Reinforce adherence to infection prevention and control measures, including hand hygiene and selection and use of personal protective equipment (PPE). Have HCP demonstrate competency with putting on and removing PPE . Make necessary Personal Protective Equipment (PPE) available in areas where resident care is provided . Facilities should have supplies of: facemasks, respirators (if available and the facility has a respiratory protection program with trained, medically cleared, and fit-tested HCP), gowns, gloves, eye protection (i.e., face shield or goggles) . HCP who work in multiple locations may pose higher risk and should be asked about exposure to facilities with recognized COVID-19 cases . 19. On 6/1/2020 at 10:23 AM, the COVID-19 Plan of Action provided by the DON documented, .screen all employees and visitors at entrance, use hand sanitizer. All employees and visitors must enter and leave through front entrance. Monitor temps (temperature) of all employees, visitors, and residents daily. Monitor for S/S (signs and symptoms) of virus of all residents and employees. No outside activities at this time including churches. Limit appointments to only the necessary ones. Call all family members and strongly encourage no visitation at this time . Hall 400 beyond double doors has been reserved for quarantine. Have selected specific individuals that will care for quarantine pts (patients) if needed. All staff in-serviced on infection control and importance of good hand washing reminders of good hand washing placed throughout hallways. Infection Control nurse and myself, (Administrator) will closely monitor CDC info on COVID-19. 20. On 6/1/2020, the DON was asked to provide all training on COVID-19 that was conducted. The DON provided one in-service dated 3/13/2020 that documented .proper handwashing/check off, PPE use, transmission of virus, proper cough and sneeze etiquette, standard precautions, transmission-based precautions, handwashing, and gloving procedures, gown, mask, eye shield. The DON was asked if this was all the in-servicing that's been done and she stated, Yes. 21. On 6/3/2020 at 10:34 AM, surveyors knocked on the front door, visualized LPN #1 behind the nurse's station with no mask on, the DON was behind the nurse's station on the telephone no mask on and an employee in blue scrubs was in the dining area with no mask on. The DON was informed at 10:37 AM that the Immediate Jeopardy was not removed, and another visit would occur. 22. On 6/3/2020 at 1:45 PM, surveyors knocked on the front door, visualized at screening station, Housekeeper #2 with the mask below his chin, the Administrator was in her office with the door open and had her mask below her chin. The Administrator was informed at 1:47 PM the Immediate Jeopardy remained in place and that another visit would occur. 23. On 6/4/2020 at 1:28 PM, surveyors entered the facility, staff had masks on covering nose and mouth and screening was done according to CDC guidelines. 1.) The Immediate Jeopardy was removed, and scope / severity reduced to F on 6/4/2020 at 1:28 PM when the facility implemented the following Plan of Removal. 2.) Upon notification of deficient practice from surveyor 06/1/2020, all employees/residents identify by DON that was assessed for signs/symptoms of community (communicable) disease by DON/Designee. 3.) On 6/1/2020 all staff on all (3) three shifts immediately in-serviced on following guidance by CDC regarding wearing face masks at all time to prevent the spread of COVID-19/community disease while providing care to residents and in facility, screening process of all staff at the beginning of their shift for fever and respiratory systems by actively taking their temperature and document absence of shortness of breath, cough and sore throat, all (3) shifts, and residents that may have doctor appointments and who attends [MEDICAL TREATMENT] are offered to wear a face masks, be screened and assessed upon return daily by DON/Designee. 4.) The Administrator will designated a person on all (3) shifts to screen employees before the beginning of their shift (all 3 shifts) and to screen all residents before and after return from [MEDICAL TREATMENT] for S/S of fever and respiratory symptoms by actively taking their temperature and document absence of shortness of breath, cough and sore throat. 5.) Additional face masks were available for staff on 6/1/2020 by Administrator and needed supply will be on hand at all times, all PPE will be in stock. 6.) Administrator/Designee will monitor and inspect PPE for availability weekly. 7.) Administrator/Designee will monitor daily every shift documentation on employee screening sheet for temperatures, coughing, shortness of breath/sore throat daily X 3 weeks and proper procedure for screening and assessing residents after return from [MEDICAL TREATMENT] are being followed, then 1 X week for 1 month. B. Based on observation, record review and interview, the facility failed to ensure contaminated items were placed in a designated biohazard container to reduce the potential for communicable disease and cross contamination in 1 of 1 facility. The findings are: 1. On 6/1/2020 at 1:00 PM, the Maintenance Director was asked are red bags ever placed into trash dumpsters? He stated, We never put biohazard bags in trash dumpsters. He was asked for the last biohazard pick up receipt. He stated, I'm not always here. The surveyor was provided a receipt for waste pick-up dated 11/12/18 and the next pick up scheduled was for 1/17/19. He stated, I called, and they said their last pick up was December of 2019. At 1:26 PM, the Administrator was asked if staff ever placed red biohazard bags in trash dumpster? She stated, I think they do sometimes. At 1:36 PM, the DON was asked, Who empties the biohazard barrels in resident's rooms when they're full? She stated, CNAs take them to the biohazard room at the end of their shift. 2. On 6/1/2020 at 1:42 PM, CNA #3 was asked, Where do you place the red biohazard bag when it's removed from a resident's room? She stated, 200 hall in the biohazard room. Have you ever, or have you heard of anyone placing a red biohazard bag in the trash dumpster? CNA #3 stated, I haven't seen nobody do that. At 1:46 PM, CNA #6 was asked, Where do you place the red biohazard bag when it's removed from a resident's room? She stated, It goes into red buckets on the breezeway on 200 hall. Have you ever, or have you heard of anyone placing a red biohazard bag in the trash dumpster? Stated, Personally no, but I have seen them (red bags) when I've taken trash out. She was asked when and stated, It was just this past week. 3. On 6/2/2020 at 9:37 AM, a review of the Infection Waste Management Plan documented, .Wastes from resident care areas: all waste contaminated with blood/body fluids shall be disposed of in the trash container that is lined with a red trash bag. Contaminated trash (red bags or red plastic barrels) will be picked up by Environmental Services personnel and transported by closed hamper to designated waste holding area.
F 0881 **Level of harm -** Potential for minimal harm **Residents Affected -** Many	**Implement a program that monitors antibiotic use.** Complaint # (AR 727) was substantiated, all or in part, with these findings. Based on record review, and interview the facility failed to ensure an Antibiotic Stewardship Program was developed to include protocols for antibiotic use and a system to monitor the use of antibiotics, in order to reduce the risk of antibiotic-resistant infections related to inappropriate or unnecessary antibiotic use for the residents who resided in 1 of 1 facility. This failed practice had the potential to affect all 41 residents who resided in the facility, as documented on the Census sheet dated 6/1/20. The findings are: 1. On 6/1/2020 at 10:10 a.m., the Director of Nursing (DON) was asked for the antibiotic stewardship tracking and trending for the past 3 months. At 1:25 p.m., the DON stated, I couldn't locate it, I called the Infection Prevention Nurse, Licensed Practical Nurse (LPN) #3 who left a couple of weeks ago and asked her for the tracking/trending information and she stated, 'I didn't do it' and hung up on me.