STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045442	A. BUILDING _____ B. WING _____	03/12/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CAVALIER HEALTHCARE OF ENGLAND	400 STUTTGART HIGHWAY ENGLAND, AR 72046

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 0558 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Reasonably accommodate the needs and preferences of each resident.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interview, the facility failed to ensure call lights were within reach to enable residents to call for assistance for 2 (Resident #48 and #35) sampled residents. This failed practice had the potential to affect 54 residents who reside in the facility as documented on the Census and Conditions of Residents form provided by the Director of Nursing (DON) on 03/09/20 at 9:34 AM. The findings are: 1. Resident #48 had a [DIAGNOSES REDACTED]. The Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 01/24/2020 documented a score of 15 (13-15 indicates cognitively intact) on the Brief Interview for Mental Status (BIMS), independent with bed mobility, locomotion on the unit and required supervision with toilet use. a. On 03/08/20 at 12:50 PM, the resident was sitting in a chair (recliner) eating lunch. The resident's call light was behind the resident draped over bedside table handle. Photo taken. b. On 03/08/20 at 4:46 PM, a record review of the resident's Care Plan documented . Keep my call light within reach, encourage use. 2. Resident #35 had [DIAGNOSES REDACTED]. The Quarterly MDS with an ARD of 02/03/20 documented a score of 09 (08-12 indicates moderately impaired) on the BIMS, required supervision with bed mobility, transfer, locomotion on and off the unit, and toilet use. a. On 03/08/20 at 1:16 PM, the resident was lying in bed. The call light was draped over the nightstand on the opposite side of the table of the resident. Photo taken. 3. On 3/10/20 at 1:47 PM, Licensed Practical Nurse (LPN) #3 was asked, Should a resident's call light be kept within reach? She stated, Yes. 4. On 3/10/20 at 01:54 PM, Certified Nursing Assistant (CNA) #4 was asked, Should a resident's call light be kept within reach? She stated, Yes.
F 0570 **Level of harm** - Potential for minimal harm **Residents Affected** - Many	**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 was purchased or there was an alternate means of assuring the security of all personal resident funds deposited in the Trust Fund Account managed by the facility to prevent financial loss for 34 residents who had individual Trust Fund Accounts maintained by the Facility. The findings are: On 3/11/20 at 8:19 a.m., the Business Office Manager and the Administrator provide a Bank Statement: (Name of Bank) The statement dated 1/31/2020 - 2/28/2020 documented, Fifty-four thousand one hundred thirty-two dollars and forty-six cent, $54,132.46. The Surety Bond: provided by (Name of Company) documented the sum of $40,000.00 went into effect June 11, 2017. On 3/11/20 at 8:24 a.m., the Administrator was informed of the Surety Bond short fall. She replied, Thank you so much, I had no idea about this.
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 assisted to formulate Advanced Directives that documented the residents' decisions with regard to accepting or rejecting life-sustaining treatments for 8 (Residents #52, #19, #27, #5, #55, #38, #59, and #31) of the 17 sampled residents (R#41 #52, #54, #15, #160, #19, #27, #18, #36, #5, #26, #55, #48, #35, #38, #59 and #31) whose Advanced Directive forms indicated a desire to formulate an Advanced Directive. This failed practice had the potential to affect 13 residents who indicated a desire to formulate Advanced Directives according to the list provided by the Director of Nursing dated [DATE] at 3:19 p.m. The findings are: 1. Resident #27 had [DIAGNOSES REDACTED]. The 5 Day MDS with an ARD of [DATE] documented the resident scored a 13 (,[DATE] indicates cognitively intact) on a BIMS. a. The [DATE] Physician order [REDACTED]. There was no Advanced Directive found in the medical record. b. On [DATE] at 10:45 AM, the Social Service Director (SSD) was asked, Does this resident have an Advance Directive? She looked in the resident's medical record and stated, Apparently this resident does not have an Advanced Directive if it's not stapled to the Code Status in his medical record. The SSD was unable to provide a copy of an Advanced Directive for this resident. Resident has a Physician order [REDACTED]. 2. Resident #52 had [DIAGNOSES REDACTED]. The Annual MDS with an ADR of [DATE] documented the resident scored a 13 (,[DATE] indicates cognitively intact) on a BIMS. a. A POLST dated [DATE] documented, .Attempt Resuscitation/CPR (Cardiopulmonary Resuscitation), Medical Intervention: Full Treatment . in his regular medical record and his Hospice Record. b. The [DATE] Physician order [REDACTED]. There was no documentation of an Advanced Directive in the resident's medical record. c. On [DATE] at 10:43 AM, the SSD was asked, Does this resident have an Advanced Directive? She looked in the medical record and stated, Apparently this resident doesn't have one if it's not stapled to the Code Status in the record. 3. Resident #19 was admitted to the facility with [DIAGNOSES REDACTED]. The Significant MDS with an ARD of [DATE] documented the resident scored a 5 (,[DATE] indicates severely impaired) on a BIMS. a. The [DATE] Physician order [REDACTED]. No documentation was found in the resident's medical record of an Advanced Directive. The resident had a POLST dated [DATE] in his medical record. b. On [DATE] at 1:04 PM, the SSD was asked, Does this resident have an Advanced Directive? She looked in the medical record and stated, Apparently he does not have one if it's not stapled to the Code Status in his record. The SSD could not provide a copy of an Advanced Directive. 4. Resident #5 had [DIAGNOSES REDACTED]. The Significant Change MDS with an ARD of [DATE] documented a score of 02 (,[DATE] indicates severely impaired) on the BIMS. The [DATE] Physician order [REDACTED]. The resident had a POLST dated [DATE] on file. There was no Advance Directive located in the chart. 5. Resident #55 was admitted on [DATE] with a [DIAGNOSES REDACTED]. The Annual Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of [DATE] documented a score of 02 (,[DATE] indicates severely impaired) on the Brief Interview for Mental Status (BIMS). The resident had a Physician order [REDACTED]. The Advance Directive in the paper chart was not signed or dated. 6. Resident #38 had [DIAGNOSES REDACTED]. The MDS with an ARD of [DATE] documented a BIMS score of 9 (,[DATE] indicates moderately impaired). The Care Plan updated [DATE] documented, .If [MEDICAL CONDITION] occurs start CPR . communicate my choice to a full code . There was no Advance Directive in the medical record. 7. Resident #31 had [DIAGNOSES REDACTED]. The Annual MDS with an ARD of [DATE] documented a BIMS score of 2 (,[DATE] indicates severe impairment). The [DATE] Physician order [REDACTED]. There is not an Advance Directive located in the chart. 8. Resident #59 had a [DIAGNOSES REDACTED]. The POLST dated [DATE] documented a DNR with the Advance Directive box marked not available. 9. On [DATE] at 7:58 a.m., The Director of Nursing (DON) and the Medical Records nurse were asked, Is there anywhere else in the medical record where an Advance Directive would be? The DON replied, No, we knew this would be coming, our Nurse Consultants provided training on [DATE], [DATE], and [DATE] on what you were enforcing.

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

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F 0578 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 1)
F 0605 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure that each resident is free from medications that restrain them, unless needed for medical treatment.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to ensure chemical restraints were administered only in the presence of a medical symptom that required their use and did not proceed after the medical symptom had subsided. The facility also failed to ensure that when a chemical restraint was administered, the least restrictive, least sedating drug and dose were utilized to minimize the potential for adverse medication effects such as excessive sedation or falls for 1 (Resident #31) of 2 (#31 and #59) sampled residents who had orders for an Antipsychotic Medication and Dementia. This failed practice had the potential to affect 2 residents who had orders for Antipsychotic Medication for Dementia, as documented on a list provided by the Director of Nursing on 3/11/2020 at 3:19 p.m. The findings are: Resident #31 had a [DIAGNOSES REDACTED]. The Annual Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 1/9/2020 documented the resident scored 2 (0-7 indicates severe impairment) on a Brief Interview for Mental Status (BIMS), had no hallucinations, did have delusions, had no physical, verbal, or other behavioral symptoms, and received no antipsychotic medication on 7 of the last 7 days. a. A Care Plan developed 1/30/2020 was not revised to document the antipsychotic medication nor the behaviors required for the medication. b. On 02/05/2020 at 5:15 p.m. a Nurse's Note documented, .resident agitated and combative. Family here & (and) concerned. Res' (Resident's) son wanted to know if she had anything to help calm her down. Res (Resident) did not have anything for agitation or anxiety. Res' (family) stated that res was getting [MEDICATION NAME] while in the hospital, said that was the only thing that would work and wanted to know if I would call the MD (medical doctor) to get her something. MD notified received order for [MEDICATION NAME] 25mg one po (oral) now and another 25mg in two hours if the first 25mg did not help her. The nurse gave [MEDICATION NAME] 25mg, one po at 1500 (3:00 p.m.). At 1630 (4:30 p.m.) res (family) asked if res could have another dose, because res was still acting out. This nurse told res son I could give next dose at 1700 (5:00 p.m.). This nurse gave [MEDICATION NAME] 25mg one po at 1700. This nurse also received an order for [REDACTED]. The March 2020 MAR (Medication Administration Record) documented monitor for negative behaviors associated with the use of [MEDICAL CONDITION] medication use each shift. Document in nurses notes if negative behaviors noted. [DATE] resident agitated, spit meds out. c. physician's orders [REDACTED]. The DON was asked Should an order for [REDACTED]. He was asked if this constituted a chemical restraint. He hung his head down and replied, Yes, I guess it would. He was asked Can family members request a chemical restraint? He replied, No, they can't. e. On 3/11/20 20 at 1:19 p.m., the MDS Coordinator was asked, Can a family request a chemical restraint? She replied, they can but we don't get one.
F 0623 **Level of harm** - Potential for minimal harm **Residents Affected** - Many	**Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview the facility failed to notify resident representatives or Power of Attorneys (POA) and the Ombudsman in writing of resident's transfer to the hospital and/or discharge as required for 1 (Resident #59) of 2 (#5, and #59) sampled residents who had been transferred and/or discharged in the past 3 months. This failed practice had the potential to effect 11 residents who had been transferred or discharged in the past 3 months, based on a list provided by the Director of Nursing on 3/11/2020 at 3:19 p.m. The findings are: 1. Resident #59 had a [DIAGNOSES REDACTED]. a. On 3/09/2020 at 10:29 a.m., a Discharge Return Assessment with an Assessment Reference Date of 1/14/2020 documented she was sent to an Acute Hospital at 1:33 p.m. The Social Service Designee was asked for the transfer / discharge notice regarding hospitalization provided to the resident, the Resident's Representative and the Ombudsman notification. She was unable to locate the letter or Ombudsman notification.
F 0625 **Level of harm** - Potential for minimal harm **Residents Affected** - Many	**Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure the resident and/or the resident's representative was notified in writing of the facility's bed hold policy at the time of transfer or discharge, to ensure residents were informed of the policy and any potential bed hold charges for 1 (Resident #59) of 2 (#5, and #59) sampled residents who had been transferred and/or discharged in the past 3 months. This failed practice had the potential to effect 11 residents who had been transferred or discharged in the past 3 months, based on a list provided by the Director of Nursing on 3/11/2020 at 3:19 p.m. The findings are: Resident #59 had [DIAGNOSES REDACTED]. a. On 3/09/2020 at 10:29 a.m., a Discharge Return Assessment with an Assessment Reference Date of 1/14/2020 documented she was sent to an Acute Hospital at 1:33 p.m. The Social Service Designee was asked for the Bed Hold policy that was provide to the resident, Resident Representative and the Ombudsman notification, she was unable to locate the letter or ombudsman notification and stated, I guess I slipped out of my window on hers.
F 0641 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure each resident receives an accurate assessment.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure the Minimum Data Set (MDS) was accurate for 1 (Resident #48) of 1 sampled resident who used a Continuous Positive Airway Pressure ([MEDICAL CONDITION]) machine. This failed practice had the potential to affect one resident who used a [MEDICAL CONDITION] machine. The findings are: 1. Resident #48 was admitted on [DATE] with a [DIAGNOSES REDACTED]. The Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 01/24/2020 documented a score of 15 (13-15 indicates cognitively intact) on the Brief Interview for Mental Status (BIMS). a. The March 2020 physician orders [REDACTED]. [MEDICAL CONDITION] settings: Auto at 17-20 CWP (Centimeters of Water Pressure) with heated humidifier with 2 L (Liters) of Oxygen inline . Oxygen tubing for [MEDICAL CONDITION] to be changed weekly on Sundays b. On 03/09/20 at 03:33 PM, the Quarterly MDS with an ARD of 01/24/20 did not document the resident's use of Oxygen or [MEDICAL CONDITION]/ [MEDICAL CONDITION] in O0100. Special Treatments and Programs. c. 03/10/20 02:30 PM, the MDS Coordinator was asked, If a resident is on oxygen / [MEDICAL CONDITION] (Bilevel Positive Airway Pressure) / [MEDICAL CONDITION] machine should it be indicated on their MDS under section O0100 Special Treatments and Programs letter C. Oxygen therapy and letter G. [MEDICAL CONDITION]/[MEDICAL CONDITION]? She stated, Yes.
F 0655 **Level of harm** - Potential for minimal harm **Residents Affected** - Many	**Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interviews the facility failed to ensure the Baseline Care Plan developed on 03/04/20 included all treatments and or procedures necessary to properly care for the immediate needs of the resident for 1 (Resident #160) of 4 (R#19, R#48, R#59 and R#160) sampled residents who had an order for [REDACTED].#160 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Resident has not had an Admission Minimum Data Set (MDS) completed. a. The March 2020 Physician order [REDACTED].Shortness of breath. O2 (Oxygen) at 2LPM (Liters Per Minute) via NC (Nasal Cannula) as needed for SOB/SPO2 (Shortness of Breath / Peripheral Capillary Oxygen Saturation) <90%. Change Oxygen tubing q (every) Sunday. Clean O2 Filter and Concentrator each Sunday. Monitor SPO2 each shift. b. The Baseline Care Plan documented, .Resident requires assistance of 1 person for activities of daily living (ADL). Resident was admitted to (Hospice) on 03/06/2020 . The Baseline Care Plan had no documentation of Oxygen use. c. On 03/08/20 at 1:26 PM, on initial rounds resident was observed lying in bed awake. There was an oxygen concentrator at the bed side with the Oxygen mask and tubing lying on the floor not dated and not properly stored in a bag. Photo taken. The resident was asked, Do you remove your own oxygen and mask? The resident replied, No I do not, they remove it. The resident was asked, When was the last time you used your oxygen? he stated, It's been about a day now. d. On 03/10/20 at 2:30 PM, the MDS Coordinator was asked, If a Resident is admitted with Oxygen should it be included on the Baseline Care Plan? She stated, Yes, it should be.

F 0656 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure the Comprehensive Care Plan addressed individualized resident care and services for 3 (Residents #27, #36 and #52) sampled residents. This failed practice had the potential to affect 54 residents residing in the facility as documented on the Resident Census and Condition of Residents form provided

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F 0656 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 2) by the Administrator on 03/08/2020. The findings are: 1. Resident #36 was admitted on [DATE] with a [DIAGNOSES REDACTED]. The Annual Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 01/13/2020 documented a score of 15 (13-15 indicates cognitively intact) on the Brief Interview for Mental Status (BIMS), required extensive assistance with bed mobility, transfer, dressing, toilet use, personal hygiene, and bathing and had functional limitation in range of motion of the Upper extremity on one side. a. On 03/08/20 at 12:59 PM, Resident #36 was in room sitting in wheelchair. Resident's left hand was contracted with no device present. Photo taken of how far resident can open hand. b. On 03/08/20 at 05:01 PM, a record review of the resident's Care Plan does not document any interventions for the left hand contracture. c. On 03/10/20 at 02:30 PM, the MDS Coordinator was asked, If a resident has a contracture should it be Care Planned? She stated, Yes. d. On 03/11/20 at 10:52 AM, the Director of Nursing (DON) was asked, If a resident has a contracture should it be Care Planned? He stated, Yes. e. On 03/11/20 at 02:25 PM, the facility policy for Restorative Program and Activities of Daily Living documented, The facility will provide a maintenance and restorative program to assist the resident in achieving and maintaining the highest practicable outcome based on the comprehensive assessment The facility will maintain individual objectives of the Care Plan and periodic review and evaluation 2. Resident #27 had [DIAGNOSES REDACTED]. The 5 Day MDS with an ARD of 01/29/20 documented the resident scored a 13 (13-15 indicates cognitively intact) on a BIMS. a. On 03/09/20 at10:45 AM, a Comprehensive Care Plan was not found in the resident's Medical Record. b. On 03/09/20 at 2:15 PM, Licensed Practical Nurse (LPN) #1 was asked, Does this resident have a Comprehensive Care Plan? She replied, I will check and see if is completed. c. On 03/09/20 at 2:58 PM, the Administrator and LPN #1 both stated, We are doing a Process Improvement Plan (PIP) on the Comprehensive Care Plan and it is not completed yet. 3. Resident #52 had [DIAGNOSES REDACTED]. The Annual MDS with an ADR of 02/07/20 documented the resident scored a 13 (13-15 indicates cognitively intact) on a BIMS and required limited assistance of one person for Activities of Daily Living (ADL). a. On 03/09/20 at 11:00 AM, a Comprehensive Care Plan was not found in the resident's Medical Record. b. On 03/09/20 at 2:15 PM, LPN#1 was asked, Does this resident have a Comprehensive Care Plan? She replied, I will check and see if is completed. c. On 03/09/20 at 2:58 PM, LPN#1 and the Administrator both stated, We are doing a Process Improvement Plan (PIP) on the Comprehensive Care Plan and it is not completed yet. 4. On 03/09/20 at 03:30 PM, LPN#1 was asked, When is the Comprehensive Care Plan due for completion after the resident is admitted ? She stated, It should be completed in 14 days after admission. She was asked, Why are you doing a PIP on the care plans? She stated, Because the Care Plans were not being done or updated. She was asked, When did you start the PIP on the Care Plans? LPN#1 stated, We started it yesterday (Sunday 03/08/2020). Then LPN#2 said, Oh no, we started it on Friday, March 6, 2020.
F 0657 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**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 observation, record review, and interview, the facility failed to ensure Comprehensive Care Plans were reviewed and revised to meet residents' care needs for 1 (Resident #38) who was incontinent of urine and for 1 (Resident #31) who had behavior symptoms of 17 (Residents #41 #52, #54, #15, #160, #19, #27, #18, #36, #5, #26, #55, #48, #35, #38, #59 and #31) sampled residents whose Care Plans were reviewed. This failed practice had the potential to affect all 54 residents according to the Resident Census and Conditions of Residents form provided by the Director of Nursing dated [DATE]20 at 9:34 a.m. The findings are: 1. Resident #38 had [DIAGNOSES REDACTED]. The Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 1/21/2020 documented a Brief Interview for Mental Status (BIMS) total of 9 (8-12 indicates moderately impaired), frequently incontinent of urine, and rejection of care was not exhibited. a. The Care Plan updated 3/8/19 documented, I am Frequently (frequently was crossed out) occasionally incontinent of bladder .provide incontinent care following each episode noted, keep me clean, dry and odor free. b. On 3/08/2020 1:18p.m. the resident was not in the room. The bed was wet and there was an odor of urine in the room and into hall. Housekeeper #1 stated, It's like this every day. At 1:23 p.m. the resident was sitting in lobby around nurses' station, resident was clean and dry with no foul odor on her person. The resident was asked, Did you have an accident earlier? She replied, Yes, yes I did after I woke up. She was asked, Do the staff take you to the bathroom? She replied, What are you talking about. At 4:34 p.m., there was an odor of urine in the resident's room and into the hall. She was asked, Do you wear underwear? She replied, I wear pull-ups The resident came out of her room with wet pants and a wet shirt (surveyor took a picture) and went to the dining room. c. On 3/10/2020 at 12:12 p.m. Certified Nurse Assistant (CNA) #1 was asked, How often is assistance to go to the bathroom provided to (Resident #38)? The CNA stated, We try to make her get up when she's in bed but if she won't and that's pretty often. When she's in bed she just pee's, it happens all the time I've worked 11-7 (11:00 p.m. to 7:00 a.m.) and she'll tell you to stop it when you try to take her. d. On 3/10/2020 at 12:26 p.m., CNA #2 was asked, How often is assistance to go to the bathroom provided to (Resident #38)? The CNA stated, We encourage her to go every hour if she's laying down, she won't get up. 2. Resident #31 had a [DIAGNOSES REDACTED]. The Annual MDS with an ARD of 1/9/2020 documented the resident scored 2 (0-7 indicates severe impairment) on a BIMS, had no hallucinations, did have delusions, had no physical, verbal, or other behavioral symptoms, did not reject care, did exhibit wandering behavior 1-3 days, and received no antipsychotic medication on 7 of the last 7 days. a. The Care Plan dated 02/28/2020 did not reflect any behavior problems or the use of an antipsychotic. b. On 03/10/2020 at 10:40 a.m., the MDS Coordinator (MDSC) was asked, Did she have behavior problems before she was sent to the hospital? The MDSC replied, Yes. The MDSC was asked, Can you describe the behavior problems? The MDSC replied, She would resist care and push staff. The MDSC was asked, Is that enough of a reason to provide an antipsychotic medication? The MDSC replied, Yes, I think so The MDSC was asked, Should the Care Plan identify the behaviors and the antipsychotic medication? The MDSC replied, Yes The MDSC was asked, Does it? The MDSC replied, No, it doesn't.
F 0660 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Plan the resident's discharge to meet the resident's goals and needs.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure discharge planning was conducted to promote continuity of care after discharge for 2 (Resident #39 and 60) of 2 sampled residents who were discharged in the past 90 days. This failed practice had the potential to effect 11 residents who have been transferred or discharged in the past 3 months, based on a list provided by the Director of Nursing on 3/11/2020 at 3:19 p.m. The findings are: 1. Resident #39 had [DIAGNOSES REDACTED]. The Discharge return not anticipated Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of [DATE] documented a 2 (0-7 indicates severe impairment) on a Brief Interview for Mental Status (BIMS), documented discharged to community and documented yes for an active discharge planning for return to community. a. On 3/09/20 at 2:07 p.m., a record review documented on [DATE] a telephone order to Discharge home with family, Medications & belongings. b. The February 2020 Medication Administration Record [REDACTED]. c. On 3/10/20 the Care Plan documented, I have been admitted to the facility under respite care, plan to d/c (discharge) home. Goals were documented as I will achieve and maintain my highest level of functioning as possible over the next qtr (quarter). The Interventions were Provide all medications, perform all medications and provide any Tx (treatments) as ordered by my physician. At 8:07 a.m. the MDS Coordinator (MDSC) was asked, Is there any other discharge plan of care besides the one in his medical record? The MDSC replied, No, that's the discharge plan for everyone. The MDSC was asked, Didn't he go home with his family? The MDSC replied, Yes. The MDSC was asked, Shouldn't the care plan have included this information? The MDSC replied, Yes, it should have. 2. Resident #60 had [DIAGNOSES REDACTED]. The Discharge Return Not Anticipated MDS with an ARD of 12/31/19 documented a 15 (12-15 indicates cognitively intact) on a BIMS, documented discharged to community and documented yes for an active discharge planning for return to community. a. On 3/09/2020 at 2:26 p.m. A Resident Identification Data report documented Resident #60 was discharged home with Home Health, a Telephone Order from the Physician documented on 12/30/19 D/C (discharge) in AM with daughter and release meds with them, Pt (patient) lab H&H (hemoglobin and hematocrit) and PCP (primary care physician) F/U (follow up). b. On 3/10/20 at 8:41 a.m., Resident #60 only had a Baseline Care Plan that documented discharge to community as home.
F 0661 **Level of harm** - Potential for minimal harm **Residents Affected** - Many	**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**

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F 0661 **Level of harm** - Potential for minimal harm **Residents Affected** - Many	(continued... from page 3) Based on record review and interview, the facility failed to ensure a written discharge summary was completed that included a recapitulation (summary) of the resident's stay that consisted of a concise summary of the stay, course of treatment, a reconciliation of medications, and discharge plans to provide necessary medical information and recommended follow-up care for the continuing care provider for 2 (Resident #39 and 60) of 2 sampled resident who were discharged in the past 90 days. This failed practice had the potential to effect 11 residents who have been transferred or discharged in the past 3 months, based on a list provided by the Director of Nursing (DON) on 3/11/2020 at 3:19 p.m. The findings are: 1. Resident #39 had [DIAGNOSES REDACTED]. The Discharge Return Not Anticipated Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of [DATE] documented a 2 (0-7 indicates severe impairment) on a Brief Interview for Mental Status (BIMS), documented discharged to community and documented yes for an active discharge planning for return to community. On 03/10/2020 at 8:00 a.m., the DON was asked if there was a discharge summary that documented a recapitulation of stay and what medicine he took with him He replied, Yes, the nurses do that, but I believe it's documented in the old part of the (electronic) system. He was asked to provide that data. 2. Resident #60 had [DIAGNOSES REDACTED]. The Discharge Return Not Anticipated MDS with an ARD of 12/31/19 documented a 15 (12-15 indicates cognitively intact) on a BIMS, documented discharged to community and documented yes for an active discharge planning for return to community. On 03/10/2020 at 8:00 a.m., the DON was asked if there was a discharge summary that documented a recapitulation of stay and what medicine he took with him? He replied, Yes, the nurses do that, but I believe it's documented in the old part of the (electronic) system. He was asked to provide that data. 3. On 03/10/2020 at 9:30 a.m., the DON stated, We didn't find any discharge summaries.
F 0677 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide care and assistance to perform activities of daily living for any resident who is unable.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Complaint # (AR 297) was substantiated, all or in part with with these findings: Based on observation, record review, and interview, the facility failed to ensure residents' fingernails and toenails were cleaned, trimmed, and foot care was provided, to promote good personal hygiene and grooming for 8 (Resident #36, #5, #48 #52, #26, #15, #160, #35) sampled residents who were dependent for nail care. Failed to ensure hair was groomed and the appropriate dress was provided to promote good grooming for 2 (Resident #5 and #26). Failed to ensure bath/showers were provided to promote good hygiene and reduce body odors for 1 (Resident #48). These failed practices had the potential to affect 54 residents who reside in the facility as documented on the Resident Census and Conditions of Residents provided by the Director of Nursing (DON) on 03/09/20 at 9:34 AM. Should be number of residents who required dependent on staff with 1 - nail care 2 - grooming and hair care 3- bathing Not everyone in the facility. 1. Resident #15 with [DIAGNOSES REDACTED]. The Quarterly Minimum Set (MDS) with an Assessment Reference Date (ARD) of 12/24/19 documented the resident scored an 8 (8-12 indicates moderately impaired) on a Brief Interview for Mental Status (BIMS) and was independent with supervision for activities of daily living (ADL). a. The Care Plan updated 12/30/19 documented, I require assistance with my activities of daily living (ADL) functioning, I will be clean, well-groomed and free of odors over the next quarter. b. The March 2020 Physician order [REDACTED]. c. On 03/08/20 at 12:59 PM, the resident was propelling himself in the hallway in his wheelchair. The resident's fingernails had a black substance underneath them and the thumb nail on the left hand was about 1/4 inch long and jagged. Photo taken. d. On 03/09/20 at 10:06 AM, Registered Nurse (RN) #1 was asked, Who is responsible for cleaning/trimming/filing residents' fingernails and toenails? She stated, I was just assigned last week to check fingernails and toenails when I do the weekly body audits. The CNAs can trim fingernails on non-diabetic residents and the CNAs should be cleaning the resident's fingernails and toenails on shower days or whenever needed, if there is a problem it should be reported to the charge nurse. RN #1 then stated, The Podiatrist comes out and trims the resident's toenails monthly and they were here last week. RN #1 looked at this resident's fingernails, then stated, This resident needs his fingernails cleaned and trimmed and I'm going to get them done today. e. On 03/10/20 at 12:49 PM, the DON was asked if he could provide the Treatment Administration Records (TAR) for this resident regarding nail care? He stated, I will tell you now, it won't be documented on any TAR's except for the Month of March 2020 because it has not been done. 2. Resident #52 with [DIAGNOSES REDACTED]. The Annual MDS with an ADR of 02/07/20 documented the resident scored a 13 (13-15 indicates cognitively intact) on a BIMS and required limited assistance of one person for ADLs. a. The Baseline Care Plan dated 01/29/20 did not document any information concerning care of the resident's fingernails. b. The March 2020 Physicians Orders documented, Fingernails to be checked and trimmed if needed weekly per treatment nurse. c. On 03/08/20 at 1:41 PM, Resident #52 was lying in bed watching television. Resident stated, My fingernails need trimming on my left hand because they are sharp, and I can't use my left hand. The resident's fingernails had a black substance underneath them and the edges were jagged. d. On 03/10/20 at 12:20 PM, CNA #1 was asked, Who is responsible for trimming and cleaning fingernails and toenails? She stated, We are supposed to trim and clean their fingernails and toenails if they are not diabetic, but sometimes they don't give us a list of the diabetics. She was asked, When do you clean their fingernails/toenails? She stated, We are supposed to clean them when we give them a shower. e. On 03/10/20 at 11:10 PM, the DON was asked if he could provide the TARs for Resident #52 regarding nail care? He stated, I will tell you now it won't be documented on any TARs except for the Month of March 2020 because it has not been done until March. f. On 03/11/20 at 02:59PM, RN #1 was asked if Resident #52 had told her he wanted his nails trimmed especially on his left hand? She stated, No, he hasn't said anything to me, but I will trim them now. RN #1 went into Resident #52's room and asked him if he wanted his fingernails trimmed? He stated, Yes, I do want them trimmed. She then asked, Is it just your left hand or both hands? He replied, Mainly my left hand but all of them need to be trimmed. 3. Resident #160 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Resident does not have a MDS. Resident does have a Baseline Care Plan which documents resident requires assistance of 1 person for ADL. a. The March 2020 Physicians orders documented, Fingernails to be checked and trimmed if needed weekly per treatment nurse. b. On 03/08/20 at 01:22 PM, the resident was resting in bed alert and awake. The resident's fingernails had a black substance underneath them on both hands and were untrimmed with jagged edges. The resident stated, They haven't done nothing to my nails. The resident showed me his toenails and they were thick and jagged. Photo taken. c. On 03/09/20 at 10:06 AM, RN #1 was asked, Who is responsible for trimming and cleaning residents' fingernails and toenails? She stated, I was just assigned last week to check fingernails and toenails when I do the weekly body audits. The CNAs can trim fingernails on non-diabetic residents and the CNAs should be cleaning the resident's fingernails and toenails on shower days or whenever needed, and if there is a problem it should be reported to the charge nurse. She then stated, The Podiatrist comes out and trims the resident's toenails and they were here last week. d. On 03/09/20 at 10:12 AM, CNA #3 was asked, Who is responsible for trimming and cleaning resident's fingernails She stated, RN #1 is responsible for trimming the fingernails, but we are supposed to clean their fingernails on shower days or whenever needed. e. On 03/10/20 at 12:49 PM, the DON was asked if he could provide the TARs for resident #160 regarding nail care? He stated, I will tell you now it won't be documented on any TARs except for the Month of March 2020, because it has not been done. f. On 03/10/20 at 1:03 PM, the DON provided a copy of the TAR for March 2020 which documented fingernail care was done on 03/04/20. 4. The March 2020 TAR documented fingernail care was done 03/04/20 for Resident # 160, 03/06/20 for Resident #52, 03/08/20 for Resident # 15. 5. Resident #5 with [DIAGNOSES REDACTED]. The Significant Change MDS with an ARD of 12/20/2019 documented a score of 02 (00-07 indicates severely impaired) on the BIMS, required extensive assistance with dressing, eating, toilet use, and bathing and limited assistance with personal hygiene. a. The Physician order [REDACTED]. Fingernails to be checked and trimmed weekly on Tuesdays per TX (Treatment) Nurse . b. On 03/08/20 at 01:12 PM, the resident was lying in bed at a 45-90 degree angle. The resident's hair was not brushed. Photo taken. The resident's fingernails were approximately 1/4 inch long. Photo taken. c. On 03/09/20 at 2:17 PM, the resident's toenails were not trimmed and approximately 1/4(inch) long, with scaly dry skin on the feet. Photo taken. TX Nurse, RN stated Podiatrist comes every 2-3 month. d. On 03/09/20 at 02:20 PM, The TX Nurse was asked, Should resident's toenails and fingernails be left untrimmed and dirty? She stated, No. e. The March 2020 TAR documented, Fingernails to be checked and trimmed weekly on Tuesdays per TX nurse .Order date 02/23/20 Start date 03/01/20 .6A-6P . TX nurse documented on 03/03/20 as care completed. f. On 03/10/20 at 02:40 PM, the DON provided a list of residents who were seen by the Podiatrist on 02/25/20 and 02/26/20. The resident was seen by the Podiatrist but refused to let the podiatrist trim her toenails. 6. Resident #26 was admitted on [DATE] with [DIAGNOSES REDACTED]. The Admission MDS with an ARD of 01/27/20 documented a score of 05 (00-07 indicates severely impaired) on the BIMS. The

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	045442	A. BUILDING _____ B. WING _____	03/12/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CAVALIER HEALTHCARE OF ENGLAND	400 STUTTGART HIGHWAY ENGLAND, AR 72046

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 0677 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 4) resident requires limited assistance with dressing, toilet use, and personal hygiene. a. The Care Plan dated 02/07/20 documented, .Personal hygiene: Limited Assist of 1 staff . b. The Physician order [REDACTED]. c. On 03/08/20 at 01:21 PM, the resident was in a wheelchair in her room self-propelling to the door with only an adult brief on. The resident's hair was sticking straight up. Photo taken. Staff notified of resident's needs. d. On 03/08/20 at 01:33 PM, the resident was in her room in wheelchair. The resident's fingernails were approximately 1/4 long with a brown substance around the nailbeds. e. On 03/09/20 at 02:21 PM, the skin on Resident's feet was dry and scaly. Photo taken. f. The March 2020 TAR documented, Fingernails to be checked and trimmed weekly on Tuesdays per TX nurse . The TX nurse documented on 03/04/20 as care completed. 7. Resident #35 had [DIAGNOSES REDACTED]. The Quarterly MDS with an ARD of 02/03/20 documented a score of 09 (08-12 indicates moderately impaired) on the BIMS, required limited assistance with dressing, personal hygiene, and bathing. a. Physician order [REDACTED].Fingernails to be checked and trimmed weekly on Tuesdays per TX Nurse . b. On 03/08/20 at 1:16 PM, the resident was lying in bed on back with blanket pulled up. The resident's fingernails were approximately 1/2 long with a brown substance around nailbeds. Photo taken. c. On 03/09/20 at 2:18 PM, the resident's toenails were untrimmed and approximately 1/2 in length. Photo taken. d. The March 2020 TAR documented . Fingernails to be checked and trimmed weekly on Tuesdays per TX nurse . The TX nurse documented on 03/03/20 as care completed. e. On 03/10/20 at 01:47 PM, LPN #3 was asked, What is an acceptable length for fingernails? She stated, Less than 1/4 inch. If they can scratch themselves, they are too long. She was asked, How often should they be cleaned, trimmed and filed? She stated, PRN (as needed) daily for cleaning, trimmed and filed every two weeks and PRN. She was asked, Should a resident's skin on their feet be dry and scaly? She stated, No. She was asked, If they are dry and scaly what should you do? She stated, Lotion, or oil them. f. On 03/10/20 at 01:54 PM, CNA #4 was asked, Do you have sufficient time to perform ADL's without being rushed? She stated, No, ma'am. She was asked, Is assistance with ADLSs provided in a timely manner? She stated, Yes, ma'am. She was asked, Can you tell me if Resident #48 is a daily bath? She stated, Yes, ma'am she is. She was asked, Can you tell me why she did not receive her bath on 02/13/20, 02/19/20, 02/20/20, 02/22/20, 02/23/20, 02/24/20, 02/26/20, 02/27/20, 02/29/20, and 03/01/20? She stated, No, I don't know. She could have gotten it and maybe the documentation was not completed. g. On 03/10/20 at 02:33 PM, RN #1 was asked, Do you have sufficient time to perform ADLs without being rushed? She stated, Yes. She was asked, Is assistance with ADL's provided in a timely manner? She stated, Yes. She was asked, What is an acceptable length for fingernails? She stated, Depends on what the resident prefers. She was asked, How often should they be cleaned, trimmed and filed? She stated, Daily as needed, and I check their nails weekly. She was asked, Should residents' skin on their feet be dry and scaly? She stated, No. She was asked, If they are dry and scaly what should you do? She stated, Lotion, or oil them down good. She was asked, Should a residents TAR be marked as completed if the treatment wasn't performed? She stated, No. h. On 03/10/20 at 02:40 PM, a list provided by the DON of residents who were seen by the Podiatrist on 02/25/20 and 02/26/20 documented, the resident was seen by the Podiatrist but refused to let the podiatrist trim her toenails. i. On 03/11/20 at 10:52 AM, the DON was asked, Should residents' be well groomed and dressed appropriately each morning? He stated, Yes. He was asked, Should residents' have their hair brushed daily as part of their ADL grooming? He stated, Yes. He was asked, Should a resident that self-propels in their wheelchair be dressed every morning? He stated, Unless they refuse to get up. j. On 03/11/20 at 11:06 AM, CNA #5 was asked, Should residents' be well groomed and dressed appropriately each morning? She stated, Yes. She was asked, Should residents' have their hair brushed daily as part of their Activity of Daily Living (ADL) grooming? She stated, Yes. She was asked, Should a resident that self-propels in their wheelchair be dressed every morning? She stated, Yes. 8. Resident #36 had a [DIAGNOSES REDACTED]. The Annual MDS with an ARD of 1/13/2020 documented a score of 15 (13-15 indicates cognitively intact) on the BIMS, required extensive assistance with bed mobility, transfer, dressing, toilet use, personal hygiene, and bathing. a. The Care Plan updated 02/05/20 documented, I require assistance with my ADL function Extensive assistance with bed mobility, transfer, toileting, dressing, personal hygiene, extensive assist w/ bathing supervision with eating . I will be clean, well groomed, dressed and free of odors over the next qtr (quarter) . b. The March 2020 Physician order [REDACTED]. On 03/08/20 at 12:59 PM, the resident was in her room sitting in wheelchair. The resident's left hand was contracted with no device present. Photo taken of how far resident can open hand. The resident's fingernails were approximately 1 inch long with a brown substance around nailbeds. d. On 03/08/20 at 3:00 PM, the resident was asked, Do the staff assist you with getting out of bed, toileting, bathing, and grooming? The resident stated, They help me with everything I do. e. On 03/10/20 at 1:08 PM, the March 2020 TAR documented, Fingernails to be checked and trimmed weekly on Tuesdays per TX nurse . Order date 02/22/20. Start date 03/01/20 .6A-6P . Treatment nurse signed her initials on 03/02/20 as care completed. 9. Resident #48 had a [DIAGNOSES REDACTED]. The Quarterly MDS with an ARD of 01/24/2020 documented a score of 15 (13-15 indicates cognitively intact) on the BIMS, required limited assistance with dressing, personal hygiene, and bathing. a. The Care Plan dated 08/23/19 documented, Keep me clean and dry . I will bathe, groom and dress as needed . Personal hygiene: Limited assist w (with)/1 staff . b. On 03/08/20 at 2:37 PM, the resident was asked about their care and the resident stated, Last Sunday no one got a bath. I'm a daily bath and I'm incontinent and didn't get one. c. On 03/10/20 at 12:56 PM, the Bathing Record documented . Bathing . PRN .March 1, 2020 . 8 (indicates ADL activity itself did not occur and/ or non-facility staff provided care 100% of the time) . Bathing Record for February and March 2020 documented the resident did not have a shower/ bath on 02/13/20, 02/19/20, 02/20/20, 02/22/20, 02/23/20, 02/24/20, 02/26/20, 02/27/20, 02/29/20, and 03/01/20. 10. On 03/11/20 at 11:43 AM, the Grievance/Complaint/Concerns Form dated 03/02/20 provided by the DON documented, Res (residents) not getting their scheduled baths .Recommendations/Actions Taken: Addressed CNAs to give baths as requested per DON; Inserviced staff. and a (Facility) Inservice form for showers and baths conducted by the DON on 03/03/20. 11. On 03/11/20 at 2:25 PM the Finger Nail and Toe Nail Care policy provided by the DON documented, .Policy: All residents of (Facilities) shall receive foot care, including care of toenails, on a regularly scheduled basis . Staff Authorized to Perform this Procedure: Physicians or Nurse Practitioners, Licensed Nurses (L.P.N./ L.V.N. (Licensed Vocational Nurses) and R.N.), Nursing Assistants. Assessment: The nurse must trim the fingernails on the following residents: Diabetics, take anticoagulant medication, others, as appropriate or necessary. Note: Podiatrist or Nurse Practitioner trims toenails Nail care includes daily cleaning and regular trimming. Proper nail care can aid in the prevention of skin problems around the nail bed. Trimmed and smooth nails prevent the resident from accidentally scratching and injuring his/ her skin 12. On 03/11/20 at 02:25 PM, the Restorative Program and Activities of Daily Living policy provided by the DON documented, .Restorative Program and Activities of Daily Living .Policy . 3. A resident who is unable to carry out activities of daily living will receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene .Activities of Daily Living: .include the following .Bathe, dress and groom .
F 0688 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to ensure hand rolls were applied to prevent further declines in Range of Motion (ROM) for 1 (Resident #36) of 2 (Residents #36, #5) sampled residents who had contractures. This failed practice had the potential to affect 9 residents who had contractures, as documented on a list provided by the Director of Nursing on 03/11/2020. The findings are: Resident #36 had a [DIAGNOSES REDACTED]. The Annual Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 01/13/2020 documented a score of 15 (13-15 indicates cognitively intact) on the Brief Interview for Mental Status (BIMS), required extensive assistance with bed mobility, transfer, dressing, toilet use, personal hygiene, and bathing, and functional limitation of the upper extremity on one side. a. On 03/08/20 at 12:59 PM, the resident was in her room sitting in wheelchair. The resident's left hand was contracted with no device present. Photo taken of how far resident can open hand. b. On 03/08/20 at 5:01 PM, the resident's Care Plan did not document any interventions for contracture of the left hand. c. On 03/10/20 at 01:47 PM, Licensed Practical Nurse (LPN) #3 was asked, If a resident has a hand contracture should they have a device present to prevent further contracture? She stated, Yes. d. On 03/11/20 at 10:52 AM, the DON was asked, If a resident has a hand contracture should they have a device present to prevent further contracture? He stated, If it has been looked at the proper device is recommended then yes. When asked, Who would look at the contracture and make the determination? He stated, Usually physical therapy. e. On 03/11/20 at 10:59 AM, Physical Therapist # 1 was asked, If a resident has a hand contracture should they have a device present to prevent further contracture? He stated, In some cases. We just ordered a hand resting splint for this resident. The resident had one three or four years ago, but I'm not sure what happened to it. f. On 03/11/20 at 02:25

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	045442	A. BUILDING _____ B. WING _____	03/12/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
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F 0688 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 5) PM, the Contractures and Coordination of Care policy documented . Policy: Residents of Advanced Healthcare Management facilities shall be given care to prevent formation and progression of contractures and deformities Procedure: .If a contracture is assessed on a resident, the physician shall be notified .
F 0695 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide safe and appropriate respiratory care for a resident when needed.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interview the facility failed to ensure the oxygen (O2) tubing and storage bags were dated for 3 (Resident #48, #160 and #19) of 5 (Residents #5, #48, #59, #160, #19) sampled residents. This failed practice had the potential to affect 5 residents in the facility who had Physician order [REDACTED]. The findings are: 1. Resident #19 had [DIAGNOSES REDACTED]. The Significant Minimum Set (MDS) with an Assessment Reference Date (ARD) of 01/27/20 documented the resident scored a 5 (0-7 indicates severely impaired) on a Brief Interview for Mental Status (BIMS) and required extensive assistance of one person for activities of daily living (ADL). a. The Care Plan dated 01/20/20 documented, I require Oxygen related to shortness of breath. I will be free of any respiratory distress. 02/18/20 non-compliant with oxygen will not keep it on at times. O2 changed to as needed (PRN), monitor SPO2 (Peripheral Capillary Oxygen Saturation) every shift. b. The March 2020 Physician order [REDACTED]. O2 tubing to be changed weekly on Sundays. c. On 03/08/20 at 2:36 PM, Resident #19 was sitting in his wheelchair in his room visiting with his wife and daughter. Resident's Oxygen (O2) Concentrator was currently off and was sitting at the bedside without tubing or humidifier bottle on it. There were two O2 masks lying on the nightstand with tubing hanging on the floor and not properly stored in a bag. Photo taken. There was an Oxygen cylinder on the back of the resident's wheelchair with a mask in a bag dated 02/18/20. Photo taken. 2. Resident #160 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Resident does not have a MDS. Resident's Baseline Care Plan documented, required assistance of 1 person for activities of daily living (ADL). Resident was admitted to Hospice on 03/06/2020. a. The March 2020 Physician order [REDACTED].@ (Oxygen at) 2liters per minute by nasal cannula as needed for Shortness of Breath/peripheral capillary oxygen saturation (SOB/SPO2) <90%. Change Oxygen tubing every Sunday. Clean O2 filter and concentrator each Sunday. Monitor SPO2 each shift. Monitor for signs and symptoms (S/S) of fluid overload each shift and notify physician and document any S/S noted. (SOB, [MEDICAL CONDITION], Weight gain) b. On 03/08/20 at 01:26 PM, the resident was lying in bed awake. An oxygen concentrator was at the bedside with the oxygen mask and tubing lying on the floor and not properly stored in a bag. The mask and tubing were not dated. Photo taken. The resident was asked, Do you remove your own oxygen mask? The resident replied, No I do not, they remove it. He was asked, When was the last time you used your oxygen? He replied, It's been about a day now. c. On 03/09/20 at 10:18 AM, RN #1 was asked Who is responsible for changing out the Oxygen tubing/equipment? she stated, The nurse on the 6p (6:00 PM) to 6a (6:00 AM) shift on Sunday Night every week. They should change out the oxygen tubing, the mask, the humidifier bottle, if there is one and the bag and all equipment should be dated appropriately. 3. Resident #48 had a [DIAGNOSES REDACTED]. a. The Care Plan dated 08/23/19 documented, .Clean filter and change O2 tubing on 02 concentrator per facility policy. b. The March 2020 physician orders [REDACTED]. [MEDICAL CONDITION] settings: Auto at 17-20 CWP with heated humidifier with 2 L of Oxygen inline . Oxygen tubing for [MEDICAL CONDITION] to be changed weekly on Sundays c. On 03/08/20 at 12:50 PM, the resident was sitting in a chair (recliner) eating lunch in their room. The oxygen concentrator was turned off. The oxygen tubing was connected to the concentrator and the resident's [MEDICAL CONDITION] machine was not dated. The storage bag that was attached to the tubing was dated 02/18/20, and the storage bag the resident's C-PAP mask was in was not dated. d. On 03/10/20 at 01:47 PM, LPN #3 was asked, If a resident is on oxygen/[MEDICAL CONDITION]/ [MEDICAL CONDITION] machine should the oxygen tubing, and storage bags be dated? She stated, Yes. She was asked, How often should oxygen tubing, and storage bags be changed? She stated, Weekly and PRN (as needed). e. On 03/11/20 at 10:52 AM the DON was asked, If a resident is on oxygen/[MEDICAL CONDITION]/ [MEDICAL CONDITION] machine should the oxygen tubing, and storage bags be dated? He stated, Yes. He was asked, How often should oxygen tubing, and storage bags be changed? He stated, Here, it is weekly. 4. On 03/11/20 at 02:25 PM Facility policy for oxygen documents . Policy . simple mask shall be changed weekly, when in use .
F 0757 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure each resident's drug regimen must be free from unnecessary drugs.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure a resident's drug regimen was free of unnecessary medication, as evidenced by failure to identify and address that a Physician order [REDACTED].#31 had [DIAGNOSES REDACTED]. on 7 of the last 7 days. a. A Care Plan developed 1/30/2020 was not revised to document the antipsychotic medication nor the behaviors required for the medication. b. A physician's orders [REDACTED]. A Nurse's Note dated 02/05/2020 at 17:15 (5:15 p.m.) documented, .resident agitated and combative. Family here & (and) concerned; resident's (family) wanted to know if she had anything to help calm her down. Res (Resident) did not have anything for agitation or anxiety. Res (family) stated that res was getting [MEDICATION NAME] while in the hospital, said that was the only thing that would work and wanted to know if I would call the MD (Medical Doctor) to get her something. MD notified, received order for [MEDICATION NAME] 25mg (milligrams) one po (oral) now and another 25mg in two hours if the first 25mg did not help her. The nurse gave [MEDICATION NAME] 25mg, one po at 1500 (3:00 p.m.). At 1630 (4:30 p.m.) res (family) asked if res could have another dose, because res was still acting out. This nurse told res (family) I could give next dose at 1700 (5:00 p.m.), This nurse gave [MEDICATION NAME] 25mg one po at 1700. This nurse also received an order for [REDACTED]. d. The March 2020 MAR (Medication Administration Record) documented Monitor for negative behaviors associated with the use of [MEDICAL CONDITION] medication use each shift. Document in Nurses Notes if negative behaviors noted. A Nurses Note documented, [DATE] resident agitated, spit meds out. e. The DON was asked, Should an order for [REDACTED]. f. On 3/11/20 at 1:19 p.m. The MDS Coordinator (MDSC) was asked, should the behaviors and the antipsychotic medication be Care Planned? The MDSC replied, yes. The MDSC was asked, Is it? The MDSC replied, It will be before the day is out.
F 0805 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs.** Based on observation and interview, the facility failed to ensure pureed food items were blended to a smooth, lump-free consistency to minimize the risk of choking or other complications for residents who required a pureed diet for 1 of 1 meal observed. This failed practice had the potential to affect 6 residents who received pureed diets, as documented on the diet list provided by the Minimum Data Set Coordinator on 3/12/2020 at 7:42 a.m. The findings are: 1. On 3/11/2020 at 10:22 a.m., Dietary #2 washed her hands and added 6 scoops of fried rice into a container. She added the fried rice from the container and a pint of whole milk to the Robot Coupe and began blending. She opened a second carton of milk and added more milk and continued to blend mixture to a smooth consistency. She attempted to put the pureed mixture into the container that the fried rice had been in. A small amount of whole pieces of fried rice remained in the container. Picture taken. She was stopped and asked to look into the container. She was asked, What would happen if you mixed the puree with the whole pieces in the pan? She replied, Someone could choke. 2. On 3/11/2020 at 10:26 a.m., Dietary #2 drained and placed 12 boiled potatoes into a container. The skin was visible on one potato. She used a potato masher to puree the potatoes, added whole milk, butter, salt and pepper to the potatoes and continued to mix by hand until cook was satisfied. Picture taken. The mashed potatoes in the pan continued to have lumps. She was asked to remove a spoonful and smear in a bowl, a lump would not smear. Surveyor She was asked What is that? She replied, A chunk. The cook used a hand mixer to mix to smooth consistency. The potatoes contained two pieces of skin. Dietary #2 was asked to remove the skin. She did, stating, We don't want to serve that. Dietary #1 asked, Should I puree the pinto beans? She was asked, What would you do if I wasn't here? She replied, I'd puree them. 3. On 3/11/2020 at 3:19 p.m. The International Dysphagia Standardization Initiation/Pureed (IDDSI) provided by the Director of Nursing documented .Starches - pureed potatoes 9 without peels and rice without lumps.

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.** Based on observation, record review and interview, the facility failed to ensure foods stored in the refrigerator, freezer were properly sealed and dated and failed to ensure equipment was maintained in clean condition to prevent potential food borne illness for residents who received meals from 1 of 1 kitchen and failed to ensure hand hygiene was completed. These failed practices had the potential to affect 57 residents who received meals from the kitchen as documented on the list provided by the Minimum Data Set Coordinator on 3/11/2020 at 7:42 a.m. The findings are: 1. On 3/08/2020 at 12:27 p.m., the following observations were made in the refrigerator: a. Cheese cut into slices was in a Ziploc bag not sealed or dated. b. Leftover Cream of Mushroom soup was undated and unlabeled. c. Leftover Tomato soup was undated and unlabeled. d. Pimento cheese and sour cream were undated. 2. In the produce refrigerator the following observations were made: a. 1 box of fresh tomatoes were undated. b. A produce box containing shredded cabbage was undated. 3. In the 2nd freezer there was frozen

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045442	A. BUILDING _____ B. WING _____	**03/12/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CAVALIER HEALTHCARE OF ENGLAND	**400 STUTTGART HIGHWAY ENGLAND, AR 72046**

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 0812 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Many	(continued... from page 6) cookie dough and pie shells that were undated. 4. Dietary #1 was asked, Should food in the refrigerator and freezer be labeled and dated? She replied, Yes. At 12:59 p.m. a medium size pot of 1/2 full oil was noted on the deep fat fryer, the fry basket had dried food particles on all sides. Pictures taken. Dietary #1 was asked, When was the deep fryer used last? She replied, I think it was Friday, 03/06/20. 5. On 3/11/2020 at 10:15 a.m., Dietary #2 opened a second carton of milk and stuck her thumb into the milk carton opening. She was asked, Should you have stuck your thumb in the milk carton? She replied, No ma'am 6. On 3/11/2020 at 3:21 p.m., the Standard Precautions for Hand Hygiene provided by the Director of Nursing documented .it is the policy to provide patient care services that reflect the Standard Precautions Infection control practices regarding hand hygiene. 7. On 3/12/2020 at 7:44 a.m., the Administrator was asked for a policy related to the cleaning of the deep fat fryer. At 7:53 a.m. the Administrator provided the Sanitation Inspection Policy documented .it is the policy of this facility to maintain a food service area that is clean and sanitary.