STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045387	A. BUILDING _____ B. WING _____	03/13/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
BRIARWOOD NURSING AND REHABILITATION CENTER,INC	516 SO RODNEY PARHAM RD LITTLE ROCK, AR 72205

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 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' decisions as to whether they desired to have, or did have, an advanced directive, were documented in a prominent part of the clinical record, to ensure their wishes were known regarding acceptance or rejection of any life-sustaining treatments in the event of their incapacitation for 5 (Residents #299, #65, #18, #94, and #60) of 28 (Residents #299, #6, #25, #58, #40, #68, #298, #2, #34, #8, #18, #252, #64, #94, #38, #77, #61, #254, #99, #65, #17, #11, #36, #76, #96, #97, #98, #60, and #54), sampled residents whose clinical records were reviewed for advanced directive information. This failed practice had the potential to affect all 95 residents who resided in the facility, as documented on the Resident Census and Conditions of Residents form dated [DATE] at 8:10 AM. The findings are: 1. On [DATE] at 3:57 PM, the Director of Nursing (DON) provided a facility policy and procedure titled, Advance Directives which documented, .If an adult resident is incapacitated upon admission and unable to receive this information .the facility will provide advance directive information to the resident's representative in accordance with state law . 2. Resident #299 had [DIAGNOSES REDACTED]. An Admission Nursing assessment dated [DATE] documented the resident scored 9 (,[DATE] indicates moderately cognitively impaired) on a Brief Interview for Mental Status. A physician's orders [REDACTED].CPR (Cardiopulmonary Resuscitation) Full Code . There was no other documentation in the clinical record as to whether the resident had formulated or wished to formulate an advance directive. 3. Resident #65 had [DIAGNOSES REDACTED]. A Significant change Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of [DATE] documented the resident was in a persistent vegetative state a. On [DATE] at 8:55 AM, a form entitled Resuscitate/ Do Not Resuscitate Order dated [DATE], documented the resident desire, I do not want CPR, No Resuscitation. A form entitled, I have formulated a power of attorney/health care and it is attached .was unsigned and a power of attorney (POA) form was not attached. A form titled, Acceptance of Surrogate was not signed or dated. There was no other documentation in the clinical record as to whether the resident/POA had formulated or wished to formulate an advance directive. b. On [DATE] at 3:30 PM, the Director of Nursing (DON) was asked, Does this resident have an advanced directive or was the resident/responsible party offered the opportunity to formulate an advanced directive? The DON stated, The family did not do all the paperwork and the resident does not have the mental capacity to do it. 3. Resident #18 had [DIAGNOSES REDACTED]. a. On [DATE] at 2:40 PM the electronic medical record was reviewed and there was no advance directive available. b. On [DATE] at 10:50 AM after interview had been done with the Director of Nursing, the advance directive had been scanned into the medical record on [DATE]. 4. Resident #60 had [DIAGNOSES REDACTED]. A quarterly MDS with an ARD of [DATE] documented the resident scored 6 (,[DATE] indicated severely impaired) on a BIMS. a. On [DATE] at 3:39 PM, the resident had a Full Code status only in the medical chart. There was no advanced directive. b. On [DATE] at 09:27 AM, after request for advance directive was made to the Director of Nursing, a code status, not an advance directive had been scanned into the electronic medical record. 5. Resident #94 had [DIAGNOSES REDACTED]. a. On [DATE] at 4:08 PM, a record review was done. No advance directive was found the medical chart. b. On [DATE] at 9:06 AM, the facility had uploaded a document to the medical record. It was a Do Not Resuscitate documentation.
F 0623 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**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 ensure the resident and the resident's representative(s) received written notification of the transfer in a language they could understand to assure residents rights for 3 (Residents #11, 65, 94) of 7 (Residents #11, 25, 34, 38, 40, 60 and 258) sampled residents who had an unplanned hospital transfer or discharge in the last 120 days. The findings are: 1. Resident #11 had [DIAGNOSES REDACTED]. a. The Nursing Progress Notes dated 12/28/19 documented the resident had an urgent/emergency transfer to the hospital for respiratory distress/change of condition. b. On 03/12/20 at 4:10 PM, record review of the Minimum Data Set ((MDS) dated [DATE] documented the resident had a discharge return anticipated with entry to nursing home on January 8, 2020. c. On 03/12/20 at 03:05 PM, the Director of Nursing (DON) was asked to provide a copy of the facility written letters of notification of urgent care/emergency room transfers in the last 120 days. She stated she was unable to locate any written notice of transfer to the emergency room , but Here is the bed hold letter we sent. 2. Resident #65 had [DIAGNOSES REDACTED]. a. A nurse's note dated [DATE] documented, PEG (Percutaneous Endoscopic Gastrostomy) tube placement was not able to be confirmed, and resident was sent to the hospital 11/27/19 to have PEG tube replaced. b. As of 3/12/20, there was no documentation to indicate the resident and/or responsible party was provided with written notification of transfer/discharge to the hospital to protect resident rights at the time of transfer. 3. Resident #96 had [DIAGNOSES REDACTED]. a. A nurse's note dated 11/2/19 documented, .Called and spoke with (Advanced Practice Registered Nurse), order to send resident to (Hospital) for PEG tube to be replaced . b. As of 3/12/20, there was no documentation to indicate the resident and/or responsible party was provided with written notification of transfer/discharge to the hospital to protect resident rights at the time of transfer. 4. As of 3/13/20 at 10:50 AM, the DON was unable to provide any written notice of transfer provided to the resident and their family or guardian and denied that the facility had a policy regarding this.
F 0636 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months.** Based on record review and interview, the facility failed to ensure a discharge Minimum Data Set (MDS) was completed within the recommended time frame after discharge for 1 (Resident #2) of 29 residents listed on the sample list. The findings are: 1. On 3/12/20 at 2:30 PM, the medical records were reviewed. Resident #2 was discharged from the facility on 11/27/19, and a discharge MDS was not completed. The last completed MDS in the electronic chart was dated 10/08/19. 2. On 3/12/20 at

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

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F 0636 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) 2:37 PM, Licensed Practical Nurse (LPN) #1 was asked if Resident #2 had a discharge MDS completed. She looked in Resident #2's electronic chart and stated, She does not have a discharge MDS. She was asked should the resident have a discharge MDS. She stated, To my knowledge. 3. On 3/13/20 at 11:40 AM, the Director of Nursing was asked to provide a policy and procedure on their MDS management, and she stated, We don't have a policy on MDS's.
F 0689 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the facility failed to ensure maintenance services were provided to ensure the trim on the wall were maintained and in good repair to provide a safe and accident free environment in room [ROOM NUMBER]. The findings are: 1. On 03/10/2020 at 10:04 AM, in resident room [ROOM NUMBER], the trim on the floor was loose and not attached to the wall, and the base board by the bathroom door was missing. 2. On 3/13/2020 at 11:00 AM, the Director of Nursing was asked if the edges of the wall and the trim should be intact, she stated, Yes. She was asked, What could happen if the trim in the room is not intact? She stated, It is a hazard, it's a safety issue.
F 0758 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview the facility failed to ensure the antipsychotic medication, [MEDICATION NAME] ([MEDICATION NAME]) was administered only when there was a documented psychological [DIAGNOSES REDACTED].#18) of 2 (Residents #18 and #34) residents who use the drug [MEDICATION NAME]. This failed practice had the potential to affect 9 residents based on the list provided by the Director of Nursing (DON) on 3/13/20. The findings are: Resident #18 had [DIAGNOSES REDACTED]. A Quarterly Minimum Data Set with an Assessment Reference Date of 12/13/19 documented the resident was independent in cognitive skills for daily decision making and exhibited no wandering or rejection of care behaviors. a. The care plan revised on 12/30/19 documented the resident refusal of care, such as refusing to be weighed, refusing vital signs, baths, toenail care, showers, medications, feeding, and geriatric sleeves. b. The March 2020 physician's orders [REDACTED].[MEDICATION NAME] Solution Give 1 ml (milliliters) by mouth at bedtime related to Conduct Disorder, unspecified . ordered on [DATE]. c. On 03/12/20 at 1:39 PM, a review of the resident's [DIAGNOSES REDACTED]. fracture, Disorder of Lipoprotein metabolism unspecified, [MEDICAL CONDITIONS], Anxiety Disorder, Conduct Disorder, Constipation, Dysphagia, Pneumonia, Vitamin Deficiency, Pain, [MEDICAL CONDITION], General [MEDICAL CONDITIONS] Chronic Peripheral . d. The Pharmacy Medication Record Review (MRR) antipsychotics, provided by the DON on 3/12/20 at 3:43 PM, documented the consultant pharmacist had marked, unnecessary [MEDICAL CONDITION] medication. The order for [MEDICATION NAME] was started on 11/15/19, with a [DIAGNOSES REDACTED]. The Medical Doctor had responded, Continue current medication regimen with no changes . Benefits outweigh risks. No benefits or risks were documented on this form. e. On 3/13/20 at 9:17 AM, the DON was asked if the resident had an appropriate [DIAGNOSES REDACTED]. She stated, I know exactly what you are saying. Hospice actually wrote that order and they added a diagnosis. I'll have to look to see what it is. f. On 3/13/20 at 10:00 AM, the DON provided the Pharmacy MRR that documented Conduct Disorder, unspecified for the order of [MEDICATION NAME] Solution 1 ml by mouth at bedtime started on 11/15/19 marked as unnecessary [MEDICAL CONDITION] Medication by the pharmacist. She was asked if this was the [DIAGNOSES REDACTED]. No targeted behaviors were listed for giving this resident this medication with an off-labeled condition. The only documented behavior was resisting care. g. On 03/13/20 at 10:59 AM, the DON was asked, What are the targeted behaviors for the usage of the [MEDICATION NAME]? She stated, She (Resident) becomes agitated and refuses care, becomes physically aggressive during care. Her most recent (incident) was with the hospice aide she became combative during her bath. She was asked, Has it been effective ([MEDICATION NAME])? She stated, Well she was on something else that was not effective and so they tried this. Even though she still has behaviors she is not as bad. She was then asked if resisting care was a good initiative to start an antipsychotic medication, and she answered, No, I know it's not a CMS (Centers for Medicaid and Medicare) reason.
F 0812 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.** Based on observation and interview, the facility failed to ensure staff washed their hands before handling clean equipment or food items, and failed to ensure food items were dated and sealed to prevent the potential for food borne illness for residents who received meals from 1 of 1 kitchen and 46 residents who received drinks in the dining room on the second floor. These failed practices had the potential to affect 92 residents who received meals from the kitchen (total census: 95) as documented on the list provided by Dietary Employee #2 on 3/12/2020. The findings are: 1. On 3/09/20 at 11:34 AM, the initial tour was conducted with Dietary Employee #2. There was a bag of lettuce, a bag of carrots, and a bag of cabbage mix in the refrigerator opened, and not dated. The bags were twisted on the ends, and not sealed properly. 2. On 3/11/20 at 9:42 AM, Dietary Employee #1 lifted the handle to the clean area of the dish machine and pulled the dish rack out. Without washing her hands, she picked up clean glasses by inserting her fingers inside the glasses as she placed them on the rack. She picked up clean plates and placed them on a cart by the plate warmer. She lifted the lid attached to the plate warmer. Without washing her hands, she picked up the plates and placed them in the warmer with her fingers touching the inner surface of the plates. At 9:43 AM, Dietary Employee #1 carried clean plates across her apron and placed them in a plate warmer with her fingers inside the plates. 3. On 3/11/20 at 10:01 AM, Dietary Employee #1 walked into the dishwashing machine room. She went straight to the clean side of the machine, picked up clean bowls and placed them on a rack with her fingers inside the bowls. She then, picked up glasses by their rims and put them on the tray. 4. On 3/11/20 at 10:55 AM, Dietary Employee #1 pushed a cart out of the way from the preparation table. Without washing her hands, she picked up a clean blade and attached it to the base of the blender to be used in pureeing food items to be served to the residents on pureed diets for lunch. 5. On 3/11/20 at 11:17 AM, Certified Nursing Assistant (CNA) #1 opened a cabinet and removed a bag of coffee from a zip lock bag. She opened another cabinet and picked up a single coffee filter. Without washing her hands, she placed the coffee bag in the filter. She then, placed the filter with coffee into the basket and back into its compartment to brew. The coffee was to be served to the residents for lunch. 6. On 3/11/20 at 11:24 AM, at the ice machine on the 2nd floor, CNA #1 picked up the ice scoop and used it to scoop ice into the glasses that had straws. As she used her hand to wedge ice from falling out of the glasses her hand was touching the ice and the tip of the straws that goes into the mouth. At 11:25 AM, CNA was asked what should you have done after touching dirty objects before handling clean equipment. She stated, I should have washed my hands.