STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045356	A. BUILDING _____ B. WING _____	**08/19/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SILOAM HEALTHCARE, LLC	**811 WEST ELGIN STREET SILOAM SPRINGS, AR 72761**

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 0609 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Complaint # (AR 097) was substantiated, all or in part, with these findings. Based on record review and interview, the facility failed to report an allegation of sexual abuse to the State Survey Agency in accordance with State law to promote protection of the resident for 1 (Resident #1) of 3 (Residents #1, #2 and #3) case mix residents. This failed practice had the potential to affect all 98 residents, according to the Daily Census dated 8/5/2020. The findings are: Resident #1 had [DIAGNOSES REDACTED]. The Admission Minimum Data Set with an Assessment Reference Date of 7/8/2020 documented the resident scored 0 (0-7 indicates severe cognitive impairments) on a Brief Interview for Mental Status and required one person assist with transfers and toileting needs. a. The Nurses Notes documented, 7/8/2020 19:00 (7:00 p.m.) . Observed res (resident) in another residents room with his hand down her pants and was trying to pull her down toward him. Nurse called his name out and asked him to come with her. He said, 'No she just needs a little of me.' Nurse stated, 'No, she is not able to defend herself or make that type of decision.' Nurse tried to redirect him by taking his free hand and stated, 'Please, come with me. Let's go to your room. You can't be in another residents room.' He stated, 'I'll show you what she needs.' 'Nurse called out in hallway for other staff to help with intervention, CNA (Certified Nursing Assistant) came to assist in redirecting resident to room . b. The Witness Statement from Certified Nursing Assistant (CNA #1) dated 7/9/20 documented, I heard Licensed Practical Nurse (LPN #1) shouting multiple times for (LPN) back in the ISO (isolation) area. I went to see what was happening. Saw (male resident) sitting on B bed while having his arms wrapped around her torso area as she was standing up. I redirected (Resident #1) back to A bed. Then redirected (male resident) to his room . c. The Incident and Accident Report dated 7/8/20 documented, . (Resident #1) . Date of Discovery 7/08/20 Time of Discovery 1900 .Family Notification Name (daughter) Date 7/09/20 Time 10:30 (a.m.) . d. The Admission Nursing Assessment and History Form documented, .7/9/2020 Time 0940 a.m (no) irritation noted R (resident) did not complain of pain (no) discharge noted pad dry examined bottom (no) irritation noted . Comments: Consent obtained from resident total of 3 staff members . e. On 8/17/2020 at 5:31 p.m., LPN #2 was asked, When did you notify your supervisor about the alleged sexual abuse allegation involving (Resident #1)? LPN #2 stated, I texted the Director of Nursing (DON) right after it happened. LPN #2 was asked, Did you notify (Resident #1's) family member after the incident? LPN #2 stated, No, I didn't want to wake her up. LPN #2 was asked, Did the (male resident) have a history of sexually inappropriate behaviors directed toward female residents? LPN #2 stated, He was sexually inappropriate toward staff. He would wander in and out of resident's rooms . I don't know if he has ever done anything like this, before. LPN #2 was asked, What happened with the (male resident) after he was found in (Resident #1's) room? LPN #2 stated, The CNA took him back to his room and gave him a snack. He didn't leave his room after that, as far as I know. LPN #2 was asked, Did a staff member stay back on the Isolation/Quarantine Hall to monitor (male resident's) whereabouts during the night? LPN #2 stated, No, we do not have the staff for that. f. On 8/18/2020 at 10:27 a.m., Registered Nurse (RN #1) was asked, When did (LPN #2) notify you regarding this sexual abuse allegation involving (Resident #1)? RN #1 stated, I got the text message in the morning (7/9/2020). We did have (LPN #2) come back up to the facility the next day. There were some conflicting stories and (LPN #2) does have high anxiety. RN #1 was asked, When did the facility notify the daughter regarding this sexual abuse allegation involving Resident #1? RN #1 stated, I think it was around 10:30 in the morning. The daughter wanted her transferred off that hall, immediately. They ended up taking her out of the facility on the same day (7/9/2020). RN #1 was asked, Did (male resident) have a history of sexually inappropriate behaviors directed toward female resident's? RN #1 stated, He would wander in and out of resident's rooms. It didn't seem to really matter male or female. He had a BIMS score of zero. He would make sexually inappropriate comments toward staff, but I never heard that he actually did anything . We have sent him out several times to different geriatric psychiatric facilities in the area . We did one-on-one observations that morning (7/9/2020) before we sent (male resident) to another psychiatric facility. He did not come back. g. On 8/19/2020 at 2:15 p.m., LPN #1 was asked, Why did the facility not report this alleged sexual abuse allegation involving Resident #1? LPN #1 stated, We did not believe it was an actual sexual abuse allegation. We had conflicting stories from the (LPN #2) and (CNA #1) . LPN #1 was asked, Did (male resident) have a history of sexually inappropriate behaviors directed toward female residents? LPN #1 stated, Not that I am aware of. He did have behaviors and would wander into other resident's rooms . He had made comments that are sexually inappropriate. LPN #1 was asked, When was the supervisory staff notified of this alleged sexual abuse allegation involving Resident #1? LPN #1 stated, I was told about it by (RN #1) when she said she received a text message from (LPN #2) that morning (7/9/2020).
F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide and implement an infection prevention and control program.** Based on record review and interview, the facility failed to ensure direct care staff members were being properly screened for COVID-19 symptoms upon entering the facility to prevent the potential for spread of COVID-19 and other infectious diseases in 1 of 1 facility. This failed practice had the potential to affect all 98 residents, according to the Daily Census dated 8/5/2020. The findings are: 1. On 8/18/2020 at 7:26 a.m., Nurse Assistant (NA #1) was asked, Is another staff member checking your temperature and having you fill out a COVID-19 screening form before starting your shift? NA #1 stated, No, we do that ourselves. I always check my temperature before I come to work. 2. On 8/18/2020 at 7:40 a.m., NA #2 was asked, Is another staff member checking your temperature and having you fill out a COVID-19 screening form before starting your shift? NA #2 stated, No, we do that ourselves. 3. On 8/18/2020 at 9:17 a.m., Certified Nursing Assistant (CNA #2) was asked, Is another staff member checking your temperature and having you fill out a COVID-19 screening form before starting your shift? CNA #2 stated, We do our screening ourselves. The thermometer and screening form are at the front entrance on a table. 4. On 8/18/2020 at 10:48 a.m., CNA #5 was asked, Is another staff member checking your temperature and having you fill out a COVID-19 screening form before starting your shift? CNA #5 stated, I do that myself. 5. On 8/18/2020 at 1:32 p.m., CNA #6 was asked, Is another staff member checking your temperature and having you fill out a COVID-19 screening form before starting your shift? CNA #6 stated, We are taking our own temperature and filling out that questionnaire when we come in. 6. On 8/19/2020 at 10:27 a.m., Registered Nurse (RN #1) was asked, Is another staff member checking your temperature and having you fill out a COVID-19 screening form before starting your shift? RN #1 stated, . The staff are not supposed to screen themselves. We did have a charge nurse go up to the front lobby at 10:15 p.m., to do the staff screenings at night. I know, I came in one night and nobody was up there to do the screenings .

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.