STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045212	A. BUILDING _____ B. WING _____	09/21/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
THE WATERS OF ROGERS, LLC	1513 SOUTH DIXIELAND RD ROGERS, AR 72758

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 0550 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to ensure the residents who were in isolation for COVID-19 were encouraged and assisted to dress in their own clothes, rather than hospital-type gowns to promote dignity for 2 (Residents #15 and #48) of 2 sampled residents on the COVID unit. This failed practice had the potential to affect 8 residents who were in isolation for COVID-19 according to a list provided by the Administrator on 09/18/2020 at 8:10 am. The findings are: 1. Resident #15 had [DIAGNOSES REDACTED]. The Quarterly Assessment Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 07/07/2020 documented the resident scored 12 (8-12 indicates moderate impairment) on a Brief Interview for Mental Status (BIMS) and required limited assistance with Activities of Daily Living. a. The Care Plan dated 1/23/19 documented, I am currently independent with most of my ADL (activities of daily living) . I am able to select my own clothing for the day. Assist/cue as needed . b. On 09/14/2020 at 2:35 pm, Resident #15 was in his room, sitting on the side of his bed, dressed in a hospital gown. Resident #15 was asked, Why are you in a hospital gown? Resident #15 stated, I don't have any pants. The resident had only 2 T-shirts hanging in the closet. The resident was asked if he was comfortable in a hospital gown? He stated, I guess, what can I do about it. c. On 09/14/2020 at 2:45 pm, Registered Nurse (RN) #1 was asked where the residents' clothes were located? RN #1 stated, When they are soiled, they are sent to the laundry and then laundry sends them back to their old room. We have to request the clothes be brought back over here (quarantine Hall) and if they are busy it might take a while? d. On 9/14/2020 at 3:00 pm, the Administrator was asked about the residents clothing and stated, We try and just take clothes. We try and not take a lot of stuff back there. She was asked, How much clothing can they take? The Administrator stated, As many as they want. The Administrator was asked why the residents were dressed in a hospital gown and no clothing was found in the closet? The Administrator stated, I don't know, they should have clothes back there. 2. Resident #48 had [DIAGNOSES REDACTED]. The Quarterly Assessment MDS with an ARD of 08/06/2020 documented the resident scored 11 (8-12 indicates moderate cognitive impairment) on a Brief Interview for Mental Status (BIMS) and required extensive assistance with Activities of Daily Living. a. The Care Plan dated 2/18/18 documented, If I am able please allow me to select my clothing for the day. b. On 09/14/2020 at 2:50 pm, Resident #48 was lying in bed, dressed in a hospital gown. RN #1 was asked where the residents' clothes were? RN #1 stated, They should be in the closet since there is no dresser in here. RN #1 then opened the closet door and the closet was empty. RN #1 then opened the drawers to the bedside table and located one pair of pants.
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 provided with the opportunity to formulate advanced directives other than code status, to enable them to make advance decisions regarding which measures should be provided or withheld in the event of their incapacitation for 9 (Residents #13, #57, #176, #38, #173, #58, #7, #15, #48) of 39 (Residents #47, #15, #51, #13, #32, #64, #67, #56, #72, #34, #24, #57, #176, #122, #50, #9, #11, #22, #18, #1, #21, #69, #74, #38, #48, #44, #23, #29, #49, #53, #14, #173, #58, #17, #42, #45, #58, #7, #71) sampled residents whose clinical records were reviewed for advanced directive information. This failed practice had the potential to affect all 75 residents who resided in the facility, according to the Resident Census provided by the Administrator on 09/14/2020 at 12:05 PM. The findings are: 1. 09/15/20 at 02:06 PM, the Administrator was asked where the advanced directives are located? The Administrator stated, They are located in the chart under documents. a. On 09/16/2020 at 08:45 AM, the Administrator presented a binder labeled Code status and Advanced Directives. The Administrator was asked where this binder was located and kept? The Administrator stated, It is located across the hall in the Medical records office. At 09:00 AM, this surveyor was unable to locate advance directives in the binder provided by the Administrator. Requested advanced directives from the Administrator. b. For Resident (R) #48, the Administrator provided a copy of the POLST (Physician order [REDACTED].#48 daughter who stated that she signed a form yesterday regarding her (resident's) resuscitation status. At 10:03 AM the Administrator was asked if the POLST form was completed yesterday after it was request? The Administrator was asked if the advance directives should have been completed at admission and prior to the time requested. The Administrator stated, Yes, it should have already been done. 2. On 09/17/2020 at 9:30 AM the administrator presented a POLST form that was incomplete for Resident #15. The Administrator stated, We were told that he had a power of attorney or health care proxy. We are unable to locate it, we asked that resident to provide a copy and he cannot locate it. He also cannot remember what attorney completed the paperwork. 3. Resident #13 had a [DIAGNOSES REDACTED]. On 9/15/20 at 11:30 am, during a review of the resident's chart, the advanced directive could not be found in the resident's chart. 4. Resident #57 had a [DIAGNOSES REDACTED]. On 9/16/20 at 10:58 am, during a review of the resident's records, the advanced directive could not be found in the electronic chart. 5. Resident #176 had a [DIAGNOSES REDACTED]. On 9/16/20 at 1:20 pm, during a review of the resident's chart, no advanced directive could be located in the electronic chart. 6. Resident #38 had [DIAGNOSES REDACTED]. On 9/15/20 at 6:53 pm, during a review of the resident's electronic record an advanced directive could not be located. 7. Resident #173 had [DIAGNOSES REDACTED]. On 9/16/20 at 8:58 am, during a review of the resident's electronic chart, no advanced directive could be located. 8. Resident #58 had [DIAGNOSES REDACTED]. On 9/16/20 at 4:34 pm, during a review of the resident's electronic chart, no advanced directive could be found. 9. Resident #7 had [DIAGNOSES REDACTED]. a. 09/16/20 09:46 AM, during a record review the Advanced Directives Acknowledgement was not found in the electronic chart. b. On 09/16/20 in the afternoon, the facility provided a ring binder book that contained Do Not Resuscitate forms, POLST forms and Advanced Directive forms. c. On 09/16/20 at 3:40 PM, the Activities Director, was asked where the book is kept, and she replied, After everyone goes home it should be kept in the front business office. She was asked, Is that office locked after the office staff leaves and she replied, Yes. She was asked, How do the nurses access if after the office staff go home and she replied, They have a green key that should open that office.
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.**

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 0636 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure that a comprehensive assessment was accurately coded to assure continuity of care for 1 (Resident #57) of 1 sampled residents who required an assessment update. This failed practice had the potential to effect 6 residents who required a comprehensive assessment in the last thirty days based on a list provided by the Minimum Data Set (MDS) Coordinator on 9/18/20 at 11:05 am. The findings are: Resident #57 had a [DIAGNOSES REDACTED]. The Quarterly Minimum Data Set (MDS) with an assessment reference date (ARD) of 6/24/20 documented the resident scored 11 (8-12 indicates moderate impairment) on a Brief Interview for Mental Status and required extensive assistance with all ADL (activity of daily living) tasks. a. A Nurse's Progress Note dated 6/30/20 at 16:17 (4:17 pm) documented, .Resident has been accepted to Center for Memory, Mood, and thought in (city). Family aware and in agreement. Medical Transport here picking up resident now . b. On 8/14/20 at 16:45 (4:45 pm) a Nurse's Progress Note documented, .Admit to facility . hs (history) of [MEDICAL CONDITION] and Dementia. VS (vital signs) are WNL (within normal limits). .Able to express needs to staff. Requires assist for all ADL's. Alert to self only and has periods of delusions . c. On 9/17/20 the review of the resident's MDS assessments documented a Discharge Return Anticipated with an ARD of 6/30/20. And an MDS assessment with the ARD of 8/14/20 documented Re-entry. d. On 9/18/20 at 10:00 am, the MDS Coordinator was asked if the resident was discharged on [DATE] and then returned on 8/14/20, (approximately 6 weeks), should his assessment have been an admission assessment instead of a re-entry and she replied, Yes, probably so.
F 0656 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**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 observation, interview and record review, the facility failed to ensure a comprehensive, individualized, and thorough care plan that included medical needs, potential side effects including monitoring and safety concerns for 1 (Resident #45) of 7 (Residents #45, #1, 22, 29, 32, 50, and #59) sampled residents taking an anticoagulant medication. This failed practice had to potential to affect 10 residents who receive anticoagulants per the list provided by the Administrator on 9/18/20 at 8:05 AM. The findings are: 1. Resident #45 had [DIAGNOSES REDACTED]. The Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 8/4/20 documented the resident was severely impaired in cognitive skills for daily decision making per a Staff Assessment of Mental Status She required total physical dependence of 2 persons for bed mobility, toileting, bathing, and total physical dependence of one person for eating, dressing and is always incontinent of bowel and bladder. a. A physician's orders [REDACTED]. b. At 09/15/20 at 11:42 AM, Resident #45 had a discolored small circular area on her outer left thigh approximately the size of a quarter and a 3 inches by 2 inch discoloration on the dependent lower area of her left upper arm. When asked, about these area on the resident, the facility treatment nurse stated she takes [MEDICATION NAME] and had a stat coagulation lab test yesterday with elevated results. c. On 9/16/20 at 10:01 AM, record review of the Care Plan found no plan of care for anticoagulant use or related possible complications of bleeding or bruising side effects. d. On 09/17/20 at 02:10 PM, The MDS Coordinator was asked if Resident #45 should have an anticoagulant therapy plan of care since she was receiving [MEDICATION NAME] and had recent critical laboratory values. She stated, I just looked for that on her care plan, I know it has been there in the past, but couldn't find it in the care plan history either . I am addressing that and putting it in her careplan.
F 0657 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**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, interview and record review, the facility failed to ensure a care plan was revised to reflect a resident's suicide attempt and measures taken to protect a resident after the return from a hospitalization for 1 (Resident #57) of 2 (Residents #57 and #176) sampled residents who had [MEDICAL CONDITION]. The failed practice had the potential to effect 3 total residents with [MEDICAL CONDITION], based on a list provided by the Administrator on 9/17/20 at 7:40 pm. The findings are: Resident #57 had [DIAGNOSES REDACTED]. The QuarterlyMinimum Data Set with an assessment reference date of 6/24/20 documented the resident scored 11 (8-12 indicates moderate cognitive impairment) on the Brief Interview for Mental Status and required extensive assistance with all ADL (activity of daily living tasks). a. The Care Plan dated 10/13/16 documented, has a history of [MEDICAL CONDITION] . There was no documentation on the care plan reflecting the resident's hospitalization on [DATE] and return on 8/14/20, monitoring for [MEDICAL CONDITION], or prevention measures after his return to the facility. b. A Nurse's Progress Note dated 6/29/20 at (2:35 pm) documented, . Staff notified this nurse that resident attempted to strangle himself twice with his call light stating that he 'didn't want to live' anymore. Upon assessment no redness noted to neck. No pain observed. Resident was immediately placed on 1:1 with CNA (Certified Nursing Assistant). APN (Advanced Practice Nurse) in facility and aware. Referral sent out to behavior health. Call back message left for (name). Resident resting in bed, with staff at bedside. No pain or discomfort noted at this time. Will continue to observe . c.A Nurse's Progress Note dated 6/29/20 at (4:17 pm) .Resident has been accepted to Center for Memory, Mood, and thought in (City) Family aware and in agreement. Emergency Transport here picking up resident now . d. A hosptial discharge summary dated 8/14/20 documented, .He had attempted suicide by wrapping the call cord around his neck at (Nursing Facility). He has attempted suicide on several occasions before this one . e. A Nurse's Progress Note dated 8/14/20 at (4:45 pm) documented, .Admit to facility with hs (history) of [MEDICAL CONDITION] and Dementia. VS (vital signs) are WNL (within normal limits). Arrived per stretcher per mobile transport Able to express needs to staff. Requires assist for all ADL's. Alert to self only and has periods of delusions . f. On 9/17/20 at 4:15 pm, the Administrator was asked what has been done to prevent any further suicide attempts and she replied, I'd have to look at his care plan. He's getting his meds (medications) as ordered, and he hasn't made any further attempts of suicide since he returned to the facility. She was asked, Does he have a call light in his room right now and she replied, I believe so .
F 0661 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**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** Based on record review and interview, the facility failed to ensure a written discharge summary was completed to include a recapitulation 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 1 (Resident #75) of 1 resident who were discharged in the past 60 days. The findings are: 1. Resident #74 had [DIAGNOSES REDACTED]. The Admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 7/31/30 documented the resident scored 0 (0-7 indicates severely impaired) on a Brief Interview for Mental status (BIMS). A Discharge Return Not Anticipated MDS with an ARD of 8/7/20 documented the resident was discharged to another nursing facility. a. A physician's orders [REDACTED]. b. The Nurses Note dated 8/7/20 documented, Resident's foley was leaking at beginning of shift. This nurse and with the assistance of, CNA (Certified Nursing Assistant), Foley cath changed . Transport here this AM to pick resident up and take her back to (Nursing Home). Transport here and resident transferred from bed to stretcher with assist of transport staff and nursing home staff. Resident's peg tube feeding was disconnected, and tubing flushed, O2 was changed to transports E-tank at 4LPM (liters per minute) [MEDICAL CONDITION]. Resident left facility on stretcher in stable condition with all personal belongings and medications. (Daughter) called and notified of resident's time of transfer and she thanked this nurse for calling. c. On 09/17/20 at 02:31 PM, the Administrator and Director of Nursing (DON) were asked for any additional discharge information pertaining to Resident #74. The Administrator stated, No official discharge summary was done, just a note. She came from a sister facility because she was COVID positive and went back to that same facility after discharge. She didn't have any personal items and her medications went with her. d. On 9/18/20 at 8:42 am, the DON was asked if discharge summaries needed to be done when residents were transferred to a different nursing facility, she stated, Yes, it is still a discharge. e. The Transfer and discharge policy and procedure provoded by the DON documented, .discharge to a lower level of care or another long term

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F 0661 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 2) care facility where the facility will be administering the resident's medications . complete a Discharge Summary Form .
F 0679 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Provide activities to meet all resident's needs.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to ensure residents who were on isolation for COVID 19 were provided person centered activities as evidence by no television in the room for 1 (Resident #15) of 2 (Residents #15 and #34) sampled residents on the COVID unit. This failed practice had the potential to affect 8 residents who were in isolation for COVID 19 according to a list provided by the Administrator on 09/18/2020 at 8:10 am. The findings are: Resident #15 had [DIAGNOSES REDACTED]. The Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 07/07/2020 documented the resident scored 12 (8-12 indicates moderate cognitive impairment) on a Brief Interview for Mental Status (BIMS) and required limited assistance with Activities of Daily Living. a. The Care Plan dated 1/19/18 documented, (Resident #15)'s preferred activities are: Staying to himself, watching tv, the resident has little or no activity involvement r/t (related to) resident wishes not to participate b. On 09/14/2020 at 2:35 p.m., Resident #15 was in his room sitting on the side of his bed. He was asked if he watched television. He stated, I do watch TV and I would be watching it if I had one. At 2:45 p.m., Licensed Practical Nurse (LPN) #1 was asked why Resident #15 did not have a television in his room? LPN #1 stated, He never requested one. c. On 09/15/2020 at 12:10 p.m., the Administrator was asked, Who was providing activities for the residents in the COVID unit? The Administrator stated, We take activities back there for them to do. We have 2 CNAs (Certified Nursing Assistant) and 1 nurse back there most days, so they do the activities. The Administrator was asked, if there were televisions in the Covid unit? The Administrator stated, Yes I believe there is TVs in all the rooms except maybe one. I believe the resident said that he didn't want it. d. On 09/16/2020 at 8:45 a.m., the Director of Nursing (DON) was asked if the resident should have a television in his room? The DON stated, Yes, I was not aware that he did not have a TV. I will get him a TV today. e. On 09/17/2020 at 3:05 p.m., Activity Aide #1 was asked what type of activities did the resident enjoyed doing? The Activity Aid stated, He enjoys watching T.V., people watching, any type of activity with food and going outside. She was asked if she was aware that the resident did not have a T.V. since he has been in isolation for COVID 19? The Activity Aide stated, No, I was not aware that he did not have a T.V. f. A policy titled Activities Program provided by the Administrator on 09/18/2020 at 9:40 a.m. stated, .4) Facility will provide activities that promote self-esteem, pleasure, comfort, education, creativity, success and independence.
F 0684 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	**Provide appropriate treatment and care according to orders, resident's preferences and goals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure measures were taken to protect a resident after the first attempt of suicide and failed to ensure monitoring was in place to keep a resident with [MEDICAL CONDITION] safe after the return to the facility for 1 (Resident #57) of 2 (Residents #57 and #176) sampled residents. This failed practice resulted in Immediate Jeopardy for Resident #57. The Administrator was notified of the Immediate Jeopardy on 9/17/20 at 5:25 pm for the facility not putting interventions in place after the resident's first suicide attempt on 6/29/20 and for not implementing safety measures after the resident's return on 8/14/20. This failed practice had the potential to affect 3 total residents in the facility with [MEDICAL CONDITION], based on a list provided by the Administrator on 9/17/20 at 7:40 pm. The findings are: 1. Resident #57 had a [DIAGNOSES REDACTED]. The Quarterly Minimum Data Set with an assessment reference date of 6/24/20 documented the resident scored 11 (8-12 indicates moderate cognitive impairment) on a Brief Interview for Mental Status and required extensive assistance with all ADL (activity of daily living) tasks. a. The Care Plan dated 10/13/16 documented, has a history of [MEDICAL CONDITION] . There was no documentation on the care plan reflecting the resident's hospitalization on [DATE] and return on 8/14/20, monitoring for [MEDICAL CONDITION], or prevention measures after his return to the facility. b. A Nurse's Progress Note dated 6/29/20 at 14:35 pm documented . Staff notified this nurse that resident attempted to strangle himself twice with his call light stating that he 'didn't want to live' anymore. Upon assessment no redness noted to neck. No pain observed. Resident was immediately placed on 1:1 with CNA (Certified Nursing Assistant). APN (Advanced Practice Nurse) in facility and aware. Referral to send out to behavior health. Call back message left for (name of relative). Resident resting in bed, with staff at bedside. No pain or discomfort noted at this time. Will continue to observe . c. A Nurse's Progress Note dated 6/29/20 at (4:06 p.m.) documented .Referral sent to (Health Facility #1) (Health Facility #2) and (Health Facility #3) for psych eval (evaluation) related to [MEDICAL CONDITION]. Health Facility #1 and #2 denied and Health Facility #3 does not have any beds available . And on 6/30/20 at 10:47 a.m., .Followed up with (Health Facility #3). No beds available. Referral sent to (Health Facility #4) . And at (4:17 p.m.) .Resident has been accepted to (Health Facility #4) in (City). Family aware and in agreement. Emergency Medical Transport here picking up resident now . d. The hospital discharge summary dated 8/14/20 documented, .He had attempted suicide by wrapping the call cord around his neck at (Nursing Facility). He has attempted suicide on several occasions before this one . e. A Nurse's Progress Note dated 8/14/20 at (4:45 p.m.) documented .Admit to facility with hs (history) of [MEDICAL CONDITION] and Dementia. VS (vital signs) are WNL (within normal limits). Arrived per stretcher per mobile transport Able to express needs to staff. Requires assist for all ADL's. Alert to self only and has periods of delusions . f. On 9/16/20 at 3:15 pm, the Administrator was asked, (after this surveyor had requested the [MEDICATION NAME] from 6/15/20 to current and could not find one for this incident), for the Incident and Accident report, to which she replied, We don't have one. When asked why there wasn't one (based on the information in the above entry) she replied, He didn't actually wrap it around his neck, he just threatened it. So, we put him one-on-one and started working on getting him sent out. I called the Nurse Consultant who said an Incident and Accident report wasn't needed. She was asked to provide a copy of the one-on-one documentation. At 3:41 pm she provided a copy of the 1 on 1 which documented the resident's constant observation began at 2:00 pm and continued until 4:00 pm the following day. g. On 9/17/20 at 2:45 pm, Licensed Practical Nurse (LPN) #4, was asked to recall the events of 6/29/20 and she replied, He wasn't actually my resident that day, but the aide came and got me and said that she found the resident with the call light cord wrapped around his neck and she had removed it from his neck. I went immediately to his room and assessed him, he didn't have any red marks on his neck, he seemed fine, and nothing was out of the ordinary. I immediately put him one-on-one with an aide and notified the APN, and the resident's family member. h. On 9/17/20 at 3:10 pm, CNA #4, was asked to recall the events of 6/29/20, and she replied, . (CNA #5) told me she had found him with the cord around his neck and put the call light cord further down in his bed were she thought he wouldn't be able to reach it, and told his nurse, but we were concerned about him so we started checking on him about every 10-15 minutes. It was about 30 or 45 minutes later I went into his room and found him with the cord wrapped around his neck. I removed the cord and put it up on the top of the wall light and grabbed the first nurse that I seen and told her. Then the resident was put one-on-one from then on. She was asked how the cord was on his neck and she stated, It was all the way around his neck, but not tight. She was asked, Did you notice any marks on his neck and she said No, there weren't any red marks on his neck. i. On 9/17/20 at 4:15 pm, the Administrator was asked what has been done to prevent any further suicide attempts and she replied, I'd have to look at his care plan. He's getting his meds as ordered, and he hasn't made any further attempts of suicide since he returned to the facility. She was asked, Does he have a call light in his room right now and she replied, I believe so, I got a tag once for a resident not having a call light. 2. Copies of Job Descriptions for the Administrator and the Director of Nursing (DON) were provided on 9/18/20 at 9:00 am. The Administrator's job description documented, .Demonstrates ability to identify and respond appropriately to potential behavioral outbursts . a. The DON's job description documented, .Reviews all Accidents and Incidents (A/I) daily and develops an appropriate plan to prevent future accidents and incidents. Conducts periodic reviews of documentation for inconsistencies on each unit .Conducts periodic reviews of Care Plans to ensure they are interdisciplinary and updated by the Charge Nurse daily as changes occur . 3. The Plan of Removal was submitted; the scope was reduced to level E and was accepted at 7:44 pm on 9/17/20 with the following documentations: 1.) The Maintenance Director applied pipe foam to resident's call light complete by 9/17/20. 2.) Resident's plan of care was updated to reflect resident's history of [MEDICAL CONDITION] with current interventions in place to include: 1. Pipe insulation foam to resident's call light. 2. Report any [MEDICAL CONDITION] to charge nurse, DON, and administrator immediately after resident is safe. 3.) Nurse to report to MD/DON/administrator if resident refuses medication. 4.) Resident to be 1:1 (one on one) if any [MEDICAL CONDITION] present. Complete by 9/17/20 5.) Staff will be in serviced before their next shift begins on reporting any [MEDICAL CONDITION] to the charge nurse, DON and/or administrator immediately after ensuring residents safety Complete by

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F 0684 **Level of harm** - Immediate jeopardy **Residents Affected** - Few	(continued... from page 3) 9/21/20. 6.) All licensed Nurses will be in serviced prior to their next shift, that when they are informed of an incident they immediately go and assess the resident. 7.) All residents with [MEDICAL CONDITION] [DIAGNOSES REDACTED]. 8.) Facility will create a post in-service test on how to handle [MEDICAL CONDITION] to ensure staff retained the training/knowledge received during in-service of [MEDICAL CONDITION]. Complete by 10/17/20. 9.) DON/Designee will review nurses notes for the last 5 months to ensure incident and Accident report was generated on any occurrences Complete by 9/21/20. 10.) Administrator/Designee will review all current resident records from the past 90 days to ensure any [MEDICAL CONDITION] was addressed appropriately and Plan of care was updated. Complete by 9/25/20.
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, interview, and record review, the facility failed to ensure devices were provided to prevent the development or further worsening of loss of mobility of joints and contractures for 1 (Resident #23) of 5 (Residents #23, 42, 45, 47, and 56) sampled residents who had contractures. This failed practice had the potential to affect 10 Residents with contractures per the list provided by the Administrator on 9/18/20 at 8:05 AM. The findings are: 1. Resident #23 had [DIAGNOSES REDACTED]. The Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 7/15/20 documented the resident was totally dependent on the physical assistance of 2 persons for bed mobility, transfers, and had impaired mobility on the upper and lower extremities. a. The Care Plan last updated on 7/10/20, documented, Alteration in musculoskeletal status r/t (related to) decreased mobility . Provide handrolls as resident will allow . b. On 9/15/20 at 9:53 AM, 9/16/20 at 10:32 AM and 2:55 PM, and on 9/17/20 at 11:04 AM the resident was lying in her bed with visible contractures to the left hand and lower extremities bilaterally and foot drop to the left lower extremity. No hand rolls, splints or other positioning devices were in use to maintain or improve range of motion. c. On 9/17/20 at 11:22 AM, the Director of Nursing (DON) was asked to accompany surveyor and look at the resident's hands for contractures. The resident had visible closed fist on the left hand, and lower extremities were bent at the knees with foot drop to the left lower extremity. She stated, She needs a handroll or something to keep that from getting worse. She came to us with contractures and limited range of motion. She stated she would have therapy evaluate her to see if they had other ideas to prevent her hands from worsening contracture. She was asked if the resident should have positioning devices between her lower extremities. The DON stated, I don't know if she can fully extend her lower extremities, I will have therapy look at her. d. The Range of Motion (ROM) Policy and Procedure provided by the Administrator on 9/18/20 documented, Policy: The Restorative Nurse and/or Nurse Designee will complete a ROM risk assessment for all residents that are admitted to the facility to determine if they have any ROM deficits and/or at risk for development of a reduction in their current ROM .
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, record review, and interview, the facility failed to ensure a portable oxygen tank was secured and stored correctly to avoid accidents and hazards for 1 (Resident #48) of 2 (Residents #48 and #49) sampled residents who had used oxygen. This failed practice had the potential to affect 4 residents who used a portable oxygen tank or had them stored in their room according to list provided by the Administrator on 09/21/2020 at 10:20 am. The findings are: Resident #48 had [DIAGNOSES REDACTED]. The Quarterly Assessment Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 08/06/2020 documented the resident scored 11 (8-12 indicates moderate cognitive impairment on a Brief Interview for Mental Status (BIMS) and required extensive assistance with Activities of Daily Living. a. On 09/14/2020 at 2:50 pm, in Resident #48's room, there was a portable oxygen cylinder with oxygen tubing connected standing in the floor near the door of the room. The portable oxygen cylinder was not in an oxygen caddy or secured. The oxygen tubing was lying in the floor. No protective bag was located on the oxygen tank. Licensed Practical Nurse (LPN) #1 was asked if the resident was on oxygen? LPN #1 entered the room and immediately removed the portable oxygen tank and tubing and stated, No she is not on oxygen. b. On 09/15/2020 at 12:10 p.m., the Administrator was asked what residents were on oxygen in the covid unit? The Administrator stated, So far no one has had to have it. The Administrator was asked why a portable oxygen tank would be sitting in a resident's room not secured or in an oxygen caddy? The Administrator stated, I do not know why it would have been there. c. On 09/16/2020 at 8:26 a.m,. the Director of Nursing (DON) was asked how the small portable oxygen tanks should be stored? The DON stated, They should be stored in the oxygen storage closet or in a dolly type thing or secured in some way. It should not be left unsecure so it can be knocked over. At 9:30 am the Nurse Consultant stated, I made sure the oxygen was stored appropriately and I am re-educating all the staff on proper storage of oxygen. d. A policy and procedure for oxygen cylinder compressed gas provided by the Administrator on 09/18/2020 at 8:46 am stated, Precautions and Hazards 1) All cylinders should be secure properly to prevent them from falling.
F 0759 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Ensure medication error rates are not 5 percent or greater.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation of the 10:00 a.m. medication pass on 09/15/20 and 08:00 a.m. medication passes on 09/17/20, record review, and interview, the facility failed to ensure physician's orders were followed to maintain a medication error rate of less than 5% to prevent potential complications for 2 (Residents #17 and #45) of 3 residents observed during the medication passes resulting in medication errors. Medication errors were made by 2 Licensed Practical Nurses (LPNs); (LPN #1 and #2) of 2 LPNs who administered medications in the facility. The medication error rate was 12% based on observation of 25 medications administered, and a total of 3 errors detected. The failed practice had the potential to affect 75 residents who received medications administered from these nurses, according to a list provided by the Administrator on 09/18/20. The findings are: 1. Resident #45 had [DIAGNOSES REDACTED]. a. A Physician Order dated 6/28/19 documented, [MEDICATION NAME] inject 8 units subcutaneously in the morning for Type 2 Diabetes. b. On 9/15/20 at 10:01 am, LPN #1 drew up 8 units in a syringe and provided to surveyor to verify. The label on the insulin vial stated open date 8/13/20 - discard after 28 days (Photo taken). c. On 9/15/20 at 10:02 am, the LPN was asked to look at the insulin label. She stated, Oh its past date, I need to discard this. The surveyor observed the LPN discard the syringe of insulin into a red biohazard container and began looking for another [MEDICATION NAME] bottle that had a current date. LPN #1 was unable to find a vial of [MEDICATION NAME] and ordered one from the pharmacy on a stat (immediate) order. 2. Resident #45 had [DIAGNOSES REDACTED]. a. A Physician Order date 8/27/20 documented, [MEDICATION NAME] Solution 0.12%. Place and dissolve 15 ml (milliliter) [MEDICATION NAME] two times a day for oral care. b. On 9/15/20 at 10:11 am LPN #1 placed approximately 9 ml of the solution into an oral syringe and squirted the liquid into the resident's closed lips. The nurse dabbed the resident's lips. The resident was observed to swallow some of the solution that the LPN squirted into her mouth over several applications. c. On 09/16/20 at 1:20 pm, LPN #1, was asked about the [MEDICATION NAME] Swish and spit used for oral care on the resident on 09/15/20. She stated that she was aware of the DO NOT SWALLOW instructions in the label and that the resident was NPO. She stated, That is why I went slowly, letting it cleanse her [MEDICATION NAME] area, then wiped any liquid off her face and chin that she spit out. She was asked if this was the way this medication was given if the resident refused to open her mouth or was unable to follow instructions? She stated, I can only answer for myself; she usually allows us to use the toothette sponge and cleanse her mouth. That was why I attempted to go slowly. I know she is NPO and not supposed to swallow it. We clarified the order yesterday to be sure the physician is aware she won't always allow the oral cleaning and what he wants us to do. She was asked if she noticed that the resident swallowed the medication and she nodded yes. 3. Resident #17 had [DIAGNOSES REDACTED]. a. A Physician Order dated 10/11/19 documented, [MEDICATION NAME] Aerosol 160-4.5mcg/ACT (micrograms/actuation) 2 puff inhale orally two times a day related to Asthma. b. On 09/17/20 at 08:20 am, LPN #2 handed the resident a [MEDICATION NAME] inhaler. The resident took first puff, waited approximately 30 seconds and took another puff. c. The LPN took the inhaler and exited room. The LPN was asked, Do you think the resident waited 1 minute between puffs? LPN #2 stated, No not really, maybe 45 seconds. When asked, Should you have instructed the resident to wait 1 minute? She stated, She is young, you don't want her having and attitude all day, you have to be careful how you approach her.
F 0760 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Ensure that residents are free from significant medication errors.**

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	045212	A. BUILDING _____ B. WING _____	09/21/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
THE WATERS OF ROGERS, LLC	1513 SOUTH DIXIELAND RD ROGERS, AR 72758

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F 0760 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 4) **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview the facility failed to follow the physician's orders to ensure residents were free of significant medication error for 1 (Resident #45) of 11 (Residents #11, 13, 15, 22, 32, 42, 45, 47, 49, 51, and 173) residents who had orders for insulin. This failed practice had the potential to affect 14 residents on Insulin according to a list provided by the Director of Nursing on 9/18/20. The findings are: 1. Resident #45 had [DIAGNOSES REDACTED]. a. A physician order dated 6/28/19 for Insulin [MEDICATION NAME] Solution 100 UNIT/ML (milliliters) Inject 8 unit subcutaneously in the morning related to Type 2 Diabetes Mellitus. b. On 09/15/20 at 10:01 AM, during the medication pass, Licensed Practical Nurse (LPN #1) drew up 8 units of [MEDICATION NAME] in an insulin syringe which she gave to the surveyor for medication pass verification. At 10:02 AM, LPN #1 was asked if this was the insulin she was going to give to Resident #45. She nodded yes. The label on the [MEDICATION NAME] vial she used had a documented open date of 8/13/20, with a label to discard after 28 days. (Photo taken) LPN #1 was asked to look at the label on the vial of [MEDICATION NAME] she was about to give to Resident #45. LPN #1 stated, Oh, its past dated, I need to discard this. LPN #1 discarded the syringe of insulin into the red biohazard container. LPN #1 checked the medication cart and the medication room and did not locate another bottle of [MEDICATION NAME] for Resident #45 that was not outdated. c. On 9/15/20 at 10:18 AM, LPN #1 stated, No other [MEDICATION NAME] for this resident was found in the medication room or cart, so I notified the physician and ordered the [MEDICATION NAME] stat (immediately) from the pharmacy because the one in the cart to use was past dated. d. The September 2020 Medication Administration Record [REDACTED]. e. On 9/17/20 at 3:10 PM, the Long Term Care Pharmacy insulin expiration dates provided by the Administrator documented, [MEDICATION NAME] ([MEDICATION NAME]) long acting refrigerate until dispensed-stable for 28 days once in use. f. The Medication Storage facility policy provided by the Admininstrator on 9/17/20 at 3:10 PM documented, .14. Outdated, contaminated, or deteriorated drugs and those in containers, which are cracked, soiled or without secure closures will be immediately withdrawn from stock. They will be disposed of according to drug disposal procedures, and reordered from the pharmacy if a current order exists. g. This is a significant error due to the condition of the resident and class of medication, Anti-Diabetic Insulin.
F 0761 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interview, the facility failed to ensure expired medications were removed and placed into an area for destruction to prevent potential administration to residents for 3 (Residents #16, #63 and #67) of 3 sampled residents who had expired medications on the medication cart. The facility also failed to dispose of influenza vaccine that had expired June 2020. The failed practice had the potential to affect all residents in the facility according to the Resident Census and Condition of Resident form dated 9/15/20. The findings are: The medication (med) cart was observed with Licensed Practical Nurse (LPN #3) in attendance, with the following: 1. Resident #63 had a card with a total of twelve [MEDICATION NAME] 4mg (milligram) left on the card, with an expiration date of 08-20. LPN #3 was ask, Can you tell me what the expiration date on the card says? She stated, 8/20. She was asked, Should it be on the cart? She stated, No. 2. Resident #16 had a card with a total of twenty-eight [MEDICATION NAME] 0.5 mg with an expiration date of 8-20. LPN #3 was asked, Can you tell me what the expiration date on the card says? She stated, 8/20. She was asked, Should it still be on the cart? She stated, No. She was asked, What should you do with expired narcotics? She stated, They should have been turned in to the DON (Director of Nursing). 3. Resident #67 had two cards with a total of seventy-one [MEDICATION NAME] 0.5 mg with an expiration date of 8-20. LPN #3 was ask, Can you tell me what the expiration date on the card says? She stated, 8/20. She was asked, Should it still be on the cart? She stated, No. She was asked, What should you do with expired narcotics? She stated, They should have been turned in to the DON. 4. On 09/17/20 at 02:40 PM, the DON was shown the cards of expired medications by LPN #3. The DON was asked, Should expired medications be on the med carts? She stated, No. 5. On 09/17/20 at 02:45 PM, 68 single dose syringe of flu vaccine with an expiration date of 6/20 was in the med room refrigerator. The DON was asked, Did you receive this vaccine this year? She stated, No, why. She was asked, What is the date of expiration? She stated, 6/20. She was asked, Should you still have it in this refrigerator? She stated, No, I will get rid of it right now.
F 0805 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs.** Based on observation, 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 pureed diets for 1 of 2 meals 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 09/18/2020 at 11:12 am. The findings are: On 09/17/2020 at 11:04 AM, Dietary Employee #2 prepared the pureed foods for the noon meal. The peach cobbler was pureed with peach juice, the sweet potatoes were pureed with 2% milk, the greens were pureed with its own juice, the pork roast was pureed with chicken broth and the bread was pureed with 2% milk. The peach cobbler, bread and sweet potatoes were smooth and had the proper consistency. The greens were grainy and contained strings and the pork roast was chunky.
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, the facility failed to ensure food items were stored in a covered sealed container and dietary employees did not contaminate food items on the steam table by handling utensils by the serving end, to prevent contamination in 1 of 1 kitchen. The facility failed to ensure that dietary knew not pick up utensils by the area used to touch the food. 1. On 09/17/2020 at 8:54 AM, there were cracks in the lids for the containers containing the thickener and granulated sugar. There was a black spot in the flour, and a large dark area in the granulated sugar bin. The Dietary Manager removed the dark spot, it appeared to be an area where the sugar had been wet and hardened. 2. On 09/17/2020 at 12:18 PM, while on the serving line, Dietary Employee #3, picked up a set of tongs to serve the pork roast. She handle the tongs by the serving end.
F 0835 **Level of harm** - Immediate jeopardy **Residents Affected** - Few	**Administer the facility in a manner that enables it to use its resources effectively and efficiently.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to implement administrative guidance, monitoring, and follow-up to protect a resident after the first attempt of suicide and failed to ensure monitoring was in place to keep the resident with [MEDICAL CONDITION] safe after the return to the facility for 1 (Resident #57) of 2 (Residents #57 and #176) sampled residents who had [MEDICAL CONDITION]. This failed practice resulted in immediate jeopardy for Resident #57. The Administrator was notified of the Immediate Jeopardy on 9/17/20 at 5:25 pm for the facility not putting interventions in place after the resident's first suicide attempt on 6/29/30 and for not implementing safety measures after the resident's return on 8/14/20. This failed practice had the potential to effect 3 total residents in the facility with [MEDICAL CONDITION], based on a list provided by the Administrator on 9/17/20 at 7:40 pm. The findings are: 1. Copies of Job Descriptions for the Administrator and the Director of Nursing (DON), were provided on 9/18/20 at 9:00 am. The Administrator's job description documented, .Demonstrates ability to identify and respond appropriately to potential behavioral outbursts . The DON's job description documented, .Reviews all Accidents and Incidents (A/I) daily and develops an appropriate plan to prevent future accidents and incidents. Conducts periodic reviews of documentation for

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F 0835 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 5) inconsistencies on each unit .Conducts periodic reviews of Care Plans to ensure they are interdisciplinary and updated by the Charge Nurse daily as changes occur . 2. Resident #57 had a [DIAGNOSES REDACTED]. The Quarterly Minimum Data Set with an assessment reference date of 6/24/20 documented the resident scored 11 (8-12 indicates moderate cognitive impairment) on a Brief Interview for Mental Status and required extensive assistance with all ADL (activity of daily living) tasks. a. The Care Plan dated 10/13/16 documented, has a history of [MEDICAL CONDITION] . There was no documentation on the care plan reflecting the resident's hospitalization on [DATE] and return on 8/14/20, monitoring for [MEDICAL CONDITION], or prevention measures after his return to the facility. b. The hospital discharge summary dated 8/14/20 documented, .He had attempted suicide by wrapping the call cord around his neck at (Nursing Facility). He has attempted suicide on several occasions before this one . c. A Nurse's Progress Note dated 6/29/20 at 14:35 pm documented . Staff notified this nurse that resident attempted to strangle himself twice with his call light stating that he 'didn't want to live' anymore. Upon assessment no redness noted to neck. No pain observed. Resident was immediately placed on 1:1 with CNA (Certified Nursing Assistant). APN (Advanced Practice Nurse) in facility and aware. Referral to send out to behavior health. Call back message left for (name of relative). Resident resting in bed, with staff at bedside. No pain or discomfort noted at this time. Will continue to observe . d. A Nurse's Progress Note dated 6/29/20 at 16:06 documented .Referral sent to (Health Facility #1) (Health Facility #2) and (Health Facility #3) for psych eval (evaluation) related to [MEDICAL CONDITION]. Health Facility #1 and #2 denied and Health Facility #3 does not have any beds available . And on 6/30/20 at 10:47 a.m., .Followed up with (Health Facility #3). No beds available. Referral sent to (Health Facility #4) . And at 16:17 .Resident has been accepted to (Health Facility #4) in (City). Family aware and in agreement. Emergency Medical Transport here picking up resident now . e. On 8/14/20 at 16:45 a Nurse's Progress Note documented .Admit to facility with hs (history) of [MEDICAL CONDITION] and Dementia. VS (vital signs) are WNL (within normal limits). Arrived per stretcher per mobile transport Able to express needs to staff. Requires assist for all ADL's. Alert to self only and has periods of delusions . f. On 9/16/20 at 3:15 pm, the Administrator was asked, (after this surveyor had requested the [MEDICATION NAME] from 6/15/20 to current and could not find one for this incident), for the Incident and Accident report, to which she replied, We don't have one. When asked why there wasn't one (based on the information in the above entry) she replied, He didn't actually wrap it around his neck, he just threatened it. So, we put him one-on-one and started working on getting him sent out. I called the Nurse Consultant who said an Incident and Accident report wasn't needed. She was asked to provide a copy of the one-on-one documentation. At 3:41 pm she provided a copy of the 1 on 1 which documented the resident's constant observation began at 2:00 pm and continued until 4:00 pm the following day. g. On 9/17/20 at 2:45 pm, Licensed Practical Nurse (LPN) #4, was asked to recall the events of 6/29/20 and she replied, He wasn't actually my resident that day, but the aide came and got me and said that she found the resident with the call light cord wrapped around his neck and she had removed it from his neck. I went immediately to his room and assessed him, he didn't have any red marks on his neck, he seemed fine, and nothing was out of the ordinary. I immediately put him one-on-one with an aide and notified the APN, and the resident's family member. h. On 9/17/20 at 3:10 pm, CNA #4, was asked to recall the events of 6/29/20, and she replied, . (CNA #5) told me she had found him with the cord around his neck and put the call light cord further down in his bed were she thought he wouldn't be able to reach it, and told his nurse, but we were concerned about him so we started checking on him about every 10-15 minutes. It was about 30 or 45 minutes later I went into his room and found him with the cord wrapped around his neck. I removed the cord and put it up on the top of the wall light and grabbed the first nurse that I seen and told her. Then the resident was put one-on-one from then on. She was asked how the cord was on his neck and she stated, It was all the way around his neck, but not tight. She was asked, Did you notice any marks on his neck and she said No, there weren't any red marks on his neck. i. On 9/17/20 at 4:15 pm, the Administrator was asked what has been done to prevent any further suicide attempts and she replied, I'd have to look at his care plan. He's getting his meds as ordered, and he hasn't made any further attempts of suicide since he returned to the facility. She was asked, Does he have a call light in his room right now and she replied, I believe so, I got a tag once for a resident not having a call light. 3. The Plan of Removal was submitted; the scope was reduced to level E and was accepted at 7:44 pm on 9/17/20 with the following documentations: 1. The Maintenance Director applied pipe foam to resident's call light complete by 9/17/20. 2. Resident's plan of care was updated to reflect resident's history of [MEDICAL CONDITION] with current interventions in place to include: 1. Pipe insulation foam to resident's call light. 2. Report any [MEDICAL CONDITION] to charge nurse, DON, and administrator immediately after resident is safe. 3. Nurse to report to MD/DON/administrator if resident refuses medication. 4. Resident to be 1:1 (one on one) if any [MEDICAL CONDITION] present. Complete by 9/17/20 5. Staff will be in services before their next shift begins on reporting any [MEDICAL CONDITION] to the charge nurse, DON and/or administrator immediately after ensuring residents safety Complete by 9/21/20. 6. All licensed Nurses will be in serviced prior to their next shift, that when they are informed of an incident they immediately go and assess the resident. 7. All residents with [MEDICAL CONDITION] [DIAGNOSES REDACTED]. 8. Facility will create a post in-service test on how to handle [MEDICAL CONDITION] to ensure staff retained the training/knowledge received during in-service of [MEDICAL CONDITION]. Complete by 10/17/20. 9. DON/Designee will review nurses notes for the last 5 months to ensure incident and Accident report was generated on any occurrences Complete by 9/21/20. 10. Administrator/Designee will review all current resident records from the past 90 days to ensure any [MEDICAL CONDITION] was addressed appropriately and Plan of care was updated. Complete by 9/25/20.
F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interview, the facility failed to ensure a resident's catheter bag was not touching the floor to prevent potential negative outcomes for 1 (Resident #38) of 3 (Residents #32, #38, and #49) sampled residents who have indwelling catheters. This failed practice had the potential to affect 3 residents with indwelling catheters based on the Roster Matrix provided by the Administrator on 9/14/20 at 12:30 pm. Failed to ensure staff changed gloves / washed hands between dirty and clean tasks during the provision of wound care to prevent potential cross-contamination or infection for 1 (Residents #32 of 2 (Residents #32 and #38) sampled residents who received wound care. This failed practice had the potential to affect 4 residents who had pressure ulcer wound care, as documented on a list provided by the DON. Failed to ensure residents were monitored for symptoms of COVID three times a day for 4 (Residents #15, #57, #48, #34) of 4 sampled residents; Failed to ensure the appropriate Personal Protective Equipment (PPE) was used when conducting COVID tests. These failed practices had the potential to affect all 75 residents according to the Census provided by the Administrator. Failed to ensure appropriate precautions and monitoring were in place to prevent the possible contamination and transfer of possible pathogens from waste food substances and soiled dishes to medications, objects, and the environment in the medication storage room. This failed practice had the potential to all affect all 76 residents taking medications in the facility per the Census provided by the Administrator on 9/15/20. The findings are: 1. Resident (R) #38 had a [DIAGNOSES REDACTED]. The Quarterly Minimum Data Set (MDS) with an assessment reference date (ARD) of 7/28/20 documented the resident scored 15 (13-15 indicates cognitively intact) on a Brief Interview for Mental Status (BIMS) and required limited assistance of one person for transfer, dressing, toilet use and had suprapubic catheter. a. On 09/15/20 at 02:40 PM, the resident was lying in bed. His foley catheter bag was lying on the floor beside his bed. b. On 09/18/20 at 10:49 AM, the Director of Nursing (DON) was asked if a catheter bag should ever be lying on the floor and she said No. 2. Resident #32 had [DIAGNOSES REDACTED]. The quarterly MDS with an ARD of 7/28/20 documented the resident scored 15 (13-15 indicates cognitively intact) on a BIMS. a. A Physician order [REDACTED].Cleanse wound to right lower back with NS, (normal saline) skin prep peri-wound, apply calcium alginate with silver to wound bed, then cover with border foam dressing 3xwk/PRN, (three times per week/as needed). b. On 09/16/20 at 01:46 PM, Licensed Practical Nurse (LPN) #1 prepared to preform wound care for the resident. The table was sanitized with Cavi-wipe, changed gloves and sanitized hands. Calcium alginate with silver, skin prep, bordered gauze foam collected and a cup with 4x4 gauze with normal saline in cup were placed on the sanitized table. LPN #1 entered room hands washed with soap and water. Dressing to the resident's back was removed and new gloves put on without sanitizing. She used two 4x4 gauze with normal saline wiping around wound first then used the second gauze to wipe in the wound. LPN #1 gloves removed and new gloves put on without sanitizing. Calcium alginate with silver placed on the wound bed. LPN #1 removed gloves and new gloves put on without sanitizing hands. Skin prep applied around wound; dressing applied. c. On 09/16/20 at 02:03 PM, LPN #1 was asked, Do you have hand sanitizer that you can carry with you? She stated, Yes. d. On 09/17/20 at 3:00 PM, the DON was asked, Should Treatment Nurse sanitize her hands during glove changes while doing treatments? She stated, Yes.

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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** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 6) 3. (R) #15 had [DIAGNOSES REDACTED]. a. R#15 most recent COVID test was collected on 9/1/20 and resulted as a positive on 9/2/20 per documentation on lab results. b. The Care Plan revised on 9/3/20 documented, .Active Infection: (R #15) has tested positive for COVID-19. This places resident at high risk for developing Acute Respiratory Distress, Secondary infections such as Pneumonia, and increased risk for Fluid Volume Deficit . c. The physician's orders [REDACTED]. d. The COVID-19 Symptom Screen for Positive Residents was completed twice a day since 9/3/20. 4. R #57 had [DIAGNOSES REDACTED]. The Quarterly MDS with an ARD of 6/24/20 documented the resident scored 11 (8-12 indicates moderate impairment) on a BIMS. a. Care Plan with a review date of 4/15/20 documented, .Potential for Exposure and Contracting COVID-19 (R #57) is at risk for exposure and contracting the [MEDICAL CONDITION] . b. The physician's orders [REDACTED].Yellow Zone: For symptomatic, suspected or residents being tested for COVID 19 - record TPR, BP, O2 Sat, BID Range (report immediately any Temp 99.6 degrees or higher) + complete the UDA: COVID Symptom Screener for Suspected Residents. Two times a day for Monitoring VS (vital signs) . c. The September 2020 Medication Administration Report (MAR) documented R#57 was screened for COVID and his vital signs taken twice a day. 5. R#48 had [DIAGNOSES REDACTED]. The Quarterly MDS with an ARD of 8/6/20 documented the resident scored 11 (8-12 indicates moderate impairment) of a BIMS. a. R#48 COVID test was collected on 9/1/20 and resulted as a positive on 9/3/20 per documentation on lab results. b. The Care Plan with a revision date of 9/3/20 documented, Active Infection: (R#48) has tested positive for COVID-19 . c. The physician's orders [REDACTED].Red Zone: For COVID 19 + residents - record TPR, BP, O2 Sat BID Range (report immediately any Temp 99.6 or higher) + complete the UDA: COVID Symptom Screener for Positive Residents . d. The COVID-19 Symptom Screen for Positive Residents was completed twice a day since 9/3/20. 6. R#34 had [DIAGNOSES REDACTED]. The Quarterly MDS with an ARD of 6/30/20 documented the resident scored 12 (8-12 indicates moderate impairment) on the BIMS. a. The physician's orders [REDACTED].Green Zone: For Non symptomatic, non + COVID Residents - Record TPR, BP, O2 Sat and S&S BID Range . two times a day for Monitoring VS and S&S (signs and symptoms) . b. The September Medication Administration Report documented R#34 was screened for COVID and had his vitals taken twice a day. 6. The ADH (Arkansas Department of Health) Guidance for Reducing Spread on COVID-19 in Long-Term Care Facilities documented, .Symptom monitoring should be increased to at least 3 times a day for residents when a positive resident or worker is identified in the facility . 7. On 09/14/2020 at 12:05 pm, the Administrator was asked how the facility was assessing the residents for signs and symptoms of COVID 19. The Administrator stated, All residents are assessed 2 times a day, the red zone has an assessment called COVID assessment for positive residents under the assessment tab of the chart, the yellow zone residents assessments are called COVID assessments for suspected residents and the green zone residents is documented on the MAR. A full set of vitals is taken, and a pulse ox (oximeter) is taken. At 12:50 pm Registered Nurse (RN) #1 was asked how the residents were assessed for signs and symptoms of COVD 19. RN #1 stated, They are assessed every 12 hours or if there is a change in the resident. It is pretty much a head to toe assessment like skilled charting. It asks for common and uncommon symptoms. 8. On 9/17/20 at 10:51 am, LPN #1 was conducting COVID testing on a staff member. LPN #1 wore a face shield, KN95 mask, and gloves. Throughout the testing process the door to the hallway remained open and a gown was never donned. a. At 11:12 at 11:51 am LPN #1 was conducting COVID testing on a staff member. LPN#1 wore a face shield, KN95 mask, and gloves. Throughout the testing process the door to the hallway remained opened and a gown was never donned. b. On 9/18/20 at 9:40 am, the DON was asked what Personal Protective Equipment (PPE) should be worn when conducting COVID tests, she stated I know I wore the N95 mask, face shield, and gloves yesterday. I don't know if I needed to have a gown on or not. 9. A document titled, Marquis Labs Testing Requisition documented, .Specimens should be collected with appropriate infection control precautions following the CDC (Centers of Disease Control and Prevention) Interim Infection Prevention and Control Recommendations for Patients with Confirmed Coronavirus Disease 2019 (COVID-19) or Persons Under Investigation for COVID-19 in Healthcare Settings . 10. A document titled, Interim Infection Prevention and Control Recommendations for Healthcare Personnel (HCP) during the Coronavirus Disease 2019 (COVID-19) Pandemic documented, .Collection of Diagnostic Respiratory Specimens . Specimen collection should be performed in a normal examination room with the door closed . HCP in the room should wear an N95 or equivalent or higher-level respirator (or facemask if a respirator is not available), eye protection, gloves, and a gown . 11. On 09/15/20 at 08:57 AM, Laundry Employee #1 was folding clean sheets with no face mask or covering applied. A N95 mask and face shield was lying on the table in the clean linen area. The employee's primary language was Spanish, and she began to speak in Spanish and then demonstrated the following: Laundry Employee #1 picked up the N95 and the face shield and pointed into the dirty area where the washers were located. She was asked if she wore PPE when in the dirty side where the washers were, she nodded her head yes. a. At 09:05 AM, the Housekeeping Supervisor was asked if PPE was worn while loading the washer? Housekeeping Supervisor stated, Yes we wear gowns, gloves, mask and face shield. She was asked when folding clean clothes or linen is PPE being worn? She stated, No, PPE is only required for dirty clothes. b. On 09/16/20 at 09:00 AM, the Nurse Consultant was asked if employees should wear a face mask while folding clean linens? The Nurse Consultant stated, I would have to look at the policy for laundry, but I would think they should be wearing a mask. 12. On 09/15/20 at 10:03 AM, the Medication room was observed with (LPN) #1 in attendance. The sink in the medication room had food substance of cooked noodles, brown substance and orange cooked carrot pieces in the sink drainer. Soiled dishes/ personal mugs were placed on the opposite right side of the sink in the medication room. a. On 9/15/20 at 10:03 AM, on the medication room counter to the left side of the sink, was an open partially full sharps red biohazard container with a red bag lying partially draped over the top corner of the sharps' container. A disposable 1/2 full 32 ounce fast food glass with a straw through the lid, with condensation on the outside of it, was placed in a 4 cup carboard holder on the medication room counter approximately 2 to 3 inches in front and to the left of the biohazard sharps container. On the left side behind the drink glass 2 open carton of soft drink were observed. (Photos were taken.) b. On 9/15/20 at 10:09 AM, LPN #1 was asked what the substance in the sink was and if the food substance, soiled dishes, drinks, and the disposable fast food cup should be in the medication room. LPN #1 stated, That is not mine, it isn't supposed to be in here. (Photos were taken) c. On 9/17/20 at 1:20 PM, LPN #2, the Infection Control Nurse, was asked if the medication storage room should have open fast food style cups with drinks and food substances and used dishes in the sink and if the drink should be placed near open sharps biohazard containers in the medication room. She stated, Never, I don't allow that, I would write someone up if I saw that. We try to tell them to keep their drinks and food in the employee break room. d. On 9/18/20 at 9:14 AM, the Director of Nursing was asked if there should be food in the sink, soiled dishes or a fast food disposable type glass with drink in the medication room near biohazard containers. She stated, No, never, that would be an infection control issue. They have the breakroom for their drinks and food/dishes.