STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045203	A. BUILDING _____ B. WING _____	**06/03/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
BATESVILLE HEALTHCARE LLC	**1975 WHITE DRIVE BATESVILLE, AR 72501**

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 0580 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Complaint # (AR 272) was substantiated, all or in part, with these findings: Based on record review and interview, the facility failed to ensure a resident's family was immediately notified of a change in condition and / or hospitalization to allow the family an opportunity to provide input on care decisions for 1 (Resident #1) of 5 (Residents #1, #2, #3, #4, and #5) case mix residents. This failed practice had the potential to affect 90 residents who resided in the facility, as documented on the Resident Census and Condition of Residents form provided by the Director of Nursing on 6/1/2020. The findings are: 1. Resident #1 had [DIAGNOSES REDACTED]. The 5-Day Minimum Data Set (MDS) with An Assessment Reference Date of 3/9/2020 documented the resident scored 15 (13-15 indicates cognitively intact) on a Brief Interview for Mental Status. a. A Nursing General Note dated 2/23/2020 at 6:43 a.m. documented, .Note Text . CNA (Certified Nursing Assistant) reported bleeding around Foley cath (catheter) . Foley cath changed under sterile technique . 16 FR (French) Foley cath inserted without difficulty and flushed easily . Resident tolerated without complaint . Will continue to monitor for change in condition . b. A Nursing Order Note dated 2/26/2020 at 14:01 (2:01 p.m.) documented, .Note Text .(At) 0745 (7:45 a.m.) this nurse was called to resident's room by staff member. Resident found to be cold, clammy, and sweating. Resident's shirt saturated in sweat. Resident's B/P (blood pressure) 74/52, P (pulse) 82, temp (temperature) 98.7, R (Respirations) 18. Resident's blood glucose checked and was 143. Resident reports he is 'just hot'. At 0750 (7:50 a.m.) notified (Name) APRN (Advanced Practice Registered Nurse) and received N.O. (New Order). Send resident to (Hospital) ER (emergency room) for evaluation and treatment as indicated. Notified (Emergency Medical Transport) (at) 0751 (7:51 a.m.), called report to (Hospital) ER (at) 0752 (7:52 a.m.) . Attempted to notify (Name) at 0757 (7:57 a.m.) but received no answer. Voicemail left to call facility, (Emergency Medical Transport) arrived at 0805 (8:05 a.m.) and resident left facility via (Emergency Medical Transport) at 0810 (8:10 a.m.). Spoke with ER (emergency room) nurse at 1300 (1:00 p.m.) and was notified resident was admitted (to hospital) . The clinical record contained no documentation indicating staff attempted to notify the family after the first failed attempt. c. On 3/30/2020 at 4:30 p.m., Licensed Practical Nurse (LPN) #2 was notified via telephone, and was asked, Do you know, or have you heard that the facility failed to notify the family of a change in condition of the resident and the resident was in the hospital? What about (Resident #1)? (Can you) Explain? LPN #2 stated, No. She was asked to explain a Nurses Note dated 2/26/2020 at 0745 (7:45 a.m.) which documented, .This nurse was called to resident's room . Send resident to (Hospital) ER (emergency room) for evaluation . at 0752 (7:52 a.m.), attempted to notify (Name) . at 757 (7:57 a.m.) but received no answer, voicemail left to call facility . At 0810 (8:10 a.m.), spoke with ER (emergency room) Nurse at 1300 (1:00 p.m.) and was notified resident was admitted (to the hospital) . She was asked, When and what time did you notify the family of his (the resident's) change of condition and that he was sent to the hospital? She stated, I called the ex-wife at 757 (7:57 a.m.) but I didn't get an answer. I left her a message. She was asked, Did you make another attempt to notify the family? She stated, I did try to call her later when I was passing meds (medications)? She was asked, Did you document that attempt? She stated, I don't see another Nurses Note, so I guess I passed it on to the other nurse. It's not documented that she (the other nurse) tried to contact the family. I did call to check on him at the hospital. The ER (emergency room) nurse told me he (the resident) was going to admitted , and that the family was at the bedside. She was asked, Did you document what the ER nurse told you? She stated, I thought I did, but I don't see it. No, I didn't. LPN #2 was asked, Should you notify the family of the resident's change of condition in a timely manner? She stated, Yes. d. On 3/31/2020 at 415 p.m., the Administrator was notified via telephone and was asked, Do you know, or have you heard that the facility failed to notify a resident or family of a change in condition of a resident, or the resident was in the hospital? What about (Resident #1)? (Can you) Explain? The Administrator stated, No. The Administrator was asked, If a resident has a change in condition or goes out to the hospital, how many attempts should your staff make to contact the family listed? She stated, Oh, if there is no answer, they should make several attempts to notify the family. She was asked, Should they document each attempt? She stated, Yes, it should be documented. She was asked to explain a Nurses Note dated 2/26/2020 at 0745 (7:45 a.m.) which documented, This nurse was called to resident's room . Send resident to (Hospital) ER (emergency room) for evaluation . At 0752 (7:52 a.m.), attempted to notify (Name) at 757 (7:57 a.m.) but received no answer. Voicemail left to call facility . At 0810 (8:10 a.m.), spoke with ER (emergency room) Nurse at 1300 (1:00 p.m.) and was notified resident was admitted (to the hospital) She was asked, When and what time was the family notified of his change of condition and that he was sent to the hospital? She stated, I have to look. There was attempt made at 7:57 a.m. and the nurse left a message. The Administrator was asked, Were there other attempts made to contact the family? If so, when, and where is it documented? She stated, I know we tried to call the ex-wife. When we called the hospital, the ER (emergency room) nurse told us the family was at the (resident's) bedside. So, there was no use in trying to notify someone, because they (the family) were there. She was asked, Is the facility responsible for notifying the family of a change in condition? She stated, Yes. She was asked, Should the family be notified of a change in condition in a timely manner? She stated, But we did. She was asked, Was it documented? She stated, They were at the hospital when we called to check on him. e. On 3/31/2020 at 4:30 p.m., the Director of Nursing (DON) was notified via telephone and was asked, Do you know, or have you heard that the facility failed to notify a resident or family of a change in condition of a resident, and the resident was in the hospital? What about (Resident #1)? (Can you) Explain? The DON stated, No. The Director of Nursing (DON) was asked, If a resident has a change in condition or goes out to the hospital, how many attempts should your staff make to contact the family listed? She stated, We make several attempts to notify the family. She was asked, Should they document each attempt? She stated, Yes, it should be documented. She was asked to explain a Nurses Note dated 2/26/2020 at 0745 that stated, .This nurse was called to resident's room . Send resident to (Hospital) ER (emergency room) for evaluation . At 0752 (7:52 a.m.), attempted to notify (Name) . At 757 (7:57 a.m.) but received no answer, voicemail left to call facility . At 0810 (8:10 a.m.), spoke with ER (emergency room) Nurse . At 1300 (1:00 p.m.) was notified resident was admitted (to the hospital) . The DON was asked, When and what time was the family notified of the resident change of condition, and he was sent to the hospital? She stated, There was an attempt made at 7:57 a.m., and the nurse left a message. The DON was asked, Were there other attempts made to contact the family? If so, when, and where is it documented? She stated, No. She was asked, Should the family be notified of a change in condition in a timely manner? The DON stated, Yes. The DON was asked, Should it be documented? The DON stated, Yes. 2. The facility policy titled Notification of Change provided by the Administrator on 3/30/2020 contained no documentation related to this deficient practice.
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.**

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 0812 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 1) **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Complaint # (AR 357) was substantiated, all or in part, with these findings: Based on record review and interview, the facility failed to ensure a sanitizing chemical solution was maintained at the correct concentration based on periodic testing, according to manufacturer's instructions, to reduce or kill microorganisms on kitchen equipment. This failed practice had the potential to affect 90 residents (Total Census: 90), as documented on the Resident Census and Conditions of Residents form dated 6/1/2020. The findings are: a. On 4/10/2020 at 8:56 a.m., Dietary Worker #1 was notified via telephone and was asked, Do you know, or have you heard the Kitchen workers are using the red sanitation buckets in the kitchen for the carts? (Can you) Explain? He stated, Yes. We use a red bucket to clean the hall carts and tables. I have one in the dish room and there is the one they use in the kitchen. We keep the towels in it, and I sanitize the carts when they come off the halls. It's not a soap, but a cleaning agent. He was asked, Do you mix it with water? He stated, No. It's already premixed with water. I just pour it in the bucket. He was asked, Where do you get the agent from. He stated, Just pour it in a 6 by 9 by 6 by 10-inch bucket, No water at all. Just sanitizer. It is already mixed with water. (The facility provided photographs of the cleaning agent.) b. On 4/10/2020 at 9:12 a.m., Dietary Worker #2, the Head Cook, was notified via telephone and was asked, Do you know, or have you heard that the Kitchen workers are using the red sanitation buckets in the kitchen for the carts? (Can you) Explain? She stated, We use 2 red sanitizer buckets to clean the carts and tables. Usually they are changed out every 4 hours, but since the [MEDICAL CONDITION], we have been changing them out every two hours. She was asked, How are the buckets changed out every two hours? She stated, Every two hours we empty the dirty water and refill with new water. We change out the rags too. She was asked, What is used in the red buckets? She stated, The sanitizer from the 3-compartment sink is mixed with the water in the bucket. c. On 4/10/2020 at 10:51 a.m., the Certified Dietary Manager (CDM) was asked, Do you know, or have you heard that the Kitchen workers are using the red sanitation buckets in the kitchen for the carts? She stated, Yes. We use one in the dish room for sanitizing the carts, and one in the kitchen prep (preparation) area for sanitizing the tables. They use the sanitizer from the three-compartment sink. The sanitizer buckets and towels are changed out every 2 hours, or before, depending on if the water is looking nasty. She was asked, Will you email me a policy, procedure, water temperatures, for the dishwashing machine, the three-compartment sink, and red sanitizer bucket? She stated, Yes. We don't take water temperatures on the three-compartment sink. We check the three-compartment sink PH (power of hydrogen) balance. The Certified Dietary Manager was asked to email pictures of the chemicals used in the red sanitizer bucket and the three-compartment sink. The Certified Dietary Manager was asked to email copies of the dishwasher, three-compartment sink, and red sanitizer buckets, temperatures, PH, and ppm (parts per million) logs. d. On 4/10/2020 at 1:28 p.m., the logs for the dishwasher and three-compartment sink were received from the facility. The logs for the red sanitizer buckets were not received from the facility. e. On 4/10/2020 at 11:23 a.m., the Environmental Supervisor was asked, Do you know, or have you heard that the kitchen workers are using the red sanitation buckets in the kitchen for the carts? He stated, Oh no. We spray the carts off after each meal and every night with a hose. If I was to walk in and seen them cleaning the carts or tables like that, I wouldn't allow it. The Certified Dietary Manager wouldn't allow that either because she's all about following the Federal Guidelines. The Housekeepers clean the tables after every meal with a disinfectant. He was asked, What type of disinfectant is used to clean the tables after every meal? He stated, The Housekeepers use a disinfectant to clean the tables. f. On 4/10/2020 at 11:50 a.m., the Administrator was asked, Do you know, or have you heard that the Kitchen workers are using the red sanitation buckets in the kitchen for the carts? She stated, Yes. (Followed with moments of silence.) They use the buckets to clean the carts and tables off. They are instructed to change the bucket out every 2 hours. The sanitizer is poured into the bucket. She was asked, Is the sanitizer mixed with anything? She stated, No. It already has water in it. The (Supplier Name) sanitizer must be mixed with a set amount water of a certain temperature and amount of water according the manufacturer's instructions. g. On 4/10/2020 at 12:52 p.m., several photographs were received from the facility via email which included: one (Supplier Name) Oasis 146 Multi-Quat Sanitizer, 2.5 US gallon (9.46 L) and one red bucket half-full of clear water and towels, and one red (Supplier Name) Sanitizing Solution Only. h. On 4/10/2020 at 1:28 p.m., the logs for the dishwasher and the three-compartment sink were received from the facility. The logs for the red sanitizer buckets were not received from the facility. i. On 4/10/2020 at 1:30 p.m., the Certified Dietary Manager was notified via telephone and was asked, Who prepares the red sanitizer bucket for the dishwasher room, and who checks PH and water temperatures on the dishwasher? She stated, (Dietary Employee #1 does. He changes the sanitizer bucket every two hours. She was asked, Who prepares the three-compartment sink sanitizer section, and who prepares the red sanitizer bucket for the kitchen? She stated, Dietary Employee #2 does that. The sanitizer water is changed every two hours. The three-compartment sink is changed out twice a day. j. On 4/10/2020 at 1:42 p.m., the Administrator was asked, Do you keep a PH log for the red sanitizer buckets PPM testing? The Administrator stated, We go by the Federal and State regulations for changing the sanitizer. We used to change it every four hours, but since the [MEDICAL CONDITION], we've been changing it every two hours. She was asked, Will you email your policy and procedure for the dishwasher, three-compartment sink, and sanitizer bucket? She stated, We don't have any. We go by the regulations. We check the sanitizer bucket PH when it's first set up the morning. She was asked, Do you keep a log of the PPM recordings for the sanitizer bucket? She stated, No. The Federal and State regulations don't say we have to keep a log. She was asked, How do you know if your sanitizer bucket solution has the correct PPM reading when sanitizing cleaning equipment? She stated, We are not required to do that, and it's not in the regulations. She was also asked, Should the manufacturer's instructions for the use of (Supplier Name) 146 Multi-Quat Sanitizer be followed? The Administrator stated, We follow the instructions on the back of bottle. She was asked, Should the (Supplier Name Sanitizer) instructions be followed for the use Multi-Quat Sanitizer? She stated, I guess I just don't understand. k. On 4/10/2020 at 1:45 p.m., Dietary Cook #2 was notified via telephone and was asked, Do you set up the solution for the red sanitizer bucket? Dietary Cook #2 stated, I do. She was asked to explain how she prepares the solution. She stated, Fill the bucket with water and add the sanitizer. She was asked, What is the red sanitizer bucket solution used for? She stated, We clean the tables and food carts with it. She was asked, How often is the solution in the bucket emptied and changed out? She stated, Every two hours I check the temperature of the water. She was asked, Where do you document the temperature of the water in the red bucket? She stated, We don't check the temperature of the water. She was asked, Where do you record the PPM of the solution used in the red bucket? She stated, I check the PPM in the morning. She was asked, Where do you document the reading of the solutions? She stated, The reading has to be 250. We get the temperature of the dishwasher and three-compartment sink three times a day. The facility was unable to provide documentation to indicate the facility was keeping a record of the red sanitizer bucket PPM before use. l. On 4/10/2020 at 2:10 p.m., the Certified Dietary Manager was asked to email the (Supplier Name) instructions for the three-compartment sink. m. On 4/10/2020 at 2:43 p.m., the instructions for the three-compartment sink were received from the facility. On 4/10/2020 at 2:244 p.m., the information for the use of the three-compartment sink was requested from the facility. On 4/10/2020 at 3:13 p.m., an email was received that included the (Supplier Name) instructions for the use of Oasis 146 Multi-Quit Sanitizer No-Rinse Quat Sanitizer and documented, . 150 to 400 PPM Quat Range-EPA-registered sanitizer for pre-cleaned use on hard, non-porous food prep surfaces and ware is effective against foodborne organisms as listed on product label. Oasis 146 Multi-Quat Sanitizer is a no-rinse quat sanitizer that is effective across a dilution range of 0.26 to 0.68 ounce per gallon of water . Sanitation Range Testing . Step 1 Testing solution should be at room temperature 65 degree Fahrenheit to 75 degree Fahrenheit (18.3 degree Celsius to 23.9 degree Celsius) . Step 2 . Withdraw and tear off approximately 2 inches of test paper from dispenser . Dip test paper for 10 seconds in test solution . Don't shake . Step 3 . Compare colors immediately with colors on the test paper package to determine PPM (parts per million) . Always Compare Against Package Scale . Step 4 . Testing Solution should be between 150 to 400 PPM* . (The Surveyor took a photograph of the instructions at this time.) n. On 4/10/2020 at 3:51 p.m., the Certified Dietary Manager was asked, Should you get a PPM reading of the solution in the red sanitizer bucket before use, and each time the solution is changed and mixed? She stated, No. We check the PH and water temperature on the dishwasher 3 times a day. We check the PPM on the three-compartment sink every time it is changed out. In the morning, we check the PPM of the sanitizer bucket right then. She was asked, Where do you record the PPM reading? She stated, It's not documented. We just do it and I know it. She was asked, How often are you preparing the solution in the red sanitizer bucket? She stated, It's done every two hours, or sooner if the water looks nasty. She was asked, Should the PPM of the solution in the red sanitizer bucket be tested before using on equipment, and should you keep a record of the PPM test readings in order to ensure the solution is in the appropriate PPM range to kill germs on kitchen equipment? She stated, When they send me a regulation that says I have to do that, I will do that. This can go any direction because that

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F 0812 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 2) is not a regulation. She was asked, Should the (Supplier Name) instructions be followed for the use of the Multi-Quat Sanitizer? She stated, There's no regulation that says we have to do that. o. On 4/10/2020 at 4:00 p.m., the Administrator was asked, Should the PPM of the solution in the red sanitizer bucket be tested before using, and should you keep a record of the PPM readings in order to ensure the solution is in the appropriate range to kill germs on equipment? She stated, When they send me a regulation that says I have to do that, I will do that. This can go any direction because that is not a regulation.
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 consistent implementation of proper infection prevention and control practices to prevent the development and transmission of COVID-19 and other communicable diseases and infections by wearing a face mask to cover the nose to prevent the potential spread of infection. This failed practice had the potential to affect 90 residents who resided in the facility, according to the Resident Census and Conditions of Residents form dated 6/1/2020 provided by the Administrator. The findings are: a. On 6/1/2020 at 1:25 p.m., the Surveyors met the Administrator on the 100 Hall of the facility and the Administrator's face mask was not covering her nose. The Surveyors explained the survey process and held an Entrance Conference with the Administrator and her mask was not covering her nose. There were residents sitting in the doorways of their rooms in the halls playing Bingo while the Administrator was on the 100 Hall. b. On 6/1/2020 at 1:26 p.m., Certified Nursing Assistant (CNA) #1 retrieved clean linens on the 100 Hall. CNA #1 was asked, What halls do you work? CNA #1 stated, The 100 and 200 Halls. The residents were sitting in the doorways of their rooms in the halls playing Bingo. c. On 6/1/2020 at 1:40 p.m., CNA #1's mask was pulled down from her face and she was looking at her phone at the Nurse's Station. She showed something on the phone to Registered Nurse (RN) #1. RN #1 pulled her mask down from her face to speak to CNA #1. The residents were sitting in the doorways of their rooms in the halls playing Bingo. d. On 6/1/2020 at 1:50 p.m., Housekeeping Aide #1 was on the 300 Hall cleaning resident rooms and her mask was not covering her nose. The residents were sitting in the doorways of their rooms playing Bingo. e. On 6/1/2020 at 1:52 p.m., Licensed Practical Nurse (LPN) #1 was sitting at the Nurse's Station and her mask was not covering her nose. The residents were sitting in the doorways of their rooms in the hallway playing Bingo. f. On 6/1/2020 at 2:09 p.m., the Maintenance Supervisor entered the facility on the 400 Hall with his mask pushed down on his chin. The Maintenance Supervisor's mask was not covering his nose or his mouth. The Administrator was walking with the Surveyors and her mask was not covering her nose. The residents were sitting in the doorways of their rooms in the halls. g. On 6/3/2020 at 9:00 a.m., the Infection Preventionist Nurse was asked, How do you wear a surgical face mask? She stated, You wash your hands, do not touch the inside or the outside of the mask, and apply mask, cover your nose and mouth, and sanitize your hands again. She was asked, When working in the facility, should you wear your mask with the nose covered? She stated, Yes. h. On 6/3/2020 at 9:04 a.m., the Director of Nursing (DON) was asked, How do you wear a surgical face mask? She stated, It goes around your ears, up on nose, and over your mouth. She was asked, When working in the facility, should you wear your mask with the nose covered? She stated, Yes. i. On 6/3/2020 at 9:10 a.m., the Administrator was asked, How do you wear a surgical face mask? She stated, We wear them throughout our shift. We provide a new one if it gets soiled. She was asked, When working in the facility, should you wear your mask with the nose covered? She stated, Yes, if you are around residents. If you are 6 feet away from residents, you can pull it down. j. A facility policy titled Masks provided by the Director of Nursing on 6/3/2020 at 9:15 a.m. via email documented, .CDC recommends wearing cloth face coverings in public settings where other social distancing measures are difficult to maintain . especially in areas of significant community-based transmission. It is critical to emphasize that maintaining 6-feet social distancing remains important to slowing the spread of [MEDICAL CONDITION] . CDC is additionally advising the use of face coverings to slow the spread of [MEDICAL CONDITION] and help people who may have [MEDICAL CONDITION] and do not know it from transmitting it to others . In a clinical setting, appropriate masks (surgical, N-95) should be worn as the case dictates . All the measures above will add a layer of protection for HCP (Healthcare Providers) working in Clinical settings . Process . 1. The cloth face coverings referenced for everyday use inside and outside the facility are not surgical masks or N-95 respirators . 2. Surgical mask and N-95 mask are critical supplies that must continue to be reserved for HCP during their shift when in contact with residents for care . 3. HCP should wear masks to the extent possible while in the facility . Anytime social distancing cannot be practiced a mask should be worn . 4. HCP should be aware that [MEDICAL CONDITION] is thought to be spread mainly from person-to-person . [MEDICAL CONDITION] can be spread even when individuals are asymptomatic . k. The Centers for Medicare and Medicaid Services (CMS) document dated May 18, 2020, Reference QSO-20-30-NH (Nursing Home) documented, .Access to adequate Personal Protective Equipment (PPE) for staff . Contingency capacity strategy is allowable . All staff wear all appropriate PPE when indicated . For the duration of the State of Emergency in their State, all long-term care facility personnel should wear a facemask while they are in the facility .