STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045450	A. BUILDING _____ B. WING _____	08/19/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MIDTOWN POST ACUTE AND REHABILITATION - A WATERS C	5720 WEST MARKHAM STREET LITTLE ROCK, AR 72205

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0554 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Allow residents to self-administer drugs if determined clinically appropriate.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Complaint (AR 293) was substantiated, all or in part, with deficiency cited at F554. Based on observation, record review, and interview, the facility failed to ensure a resident was allowed to self-administer medications, before the interdisciplinary team (IDT) conducted an assessment to determine if this practice was safe, to prevent potential complications for 2 (Residents #3 and #5) of 5 sampled residents who were observed after the 8:00 a.m. medication administration time. This had the potential to affect 16 residents who were provided medication by Licensed Practical Nurse (LPN) #1 according to a list provided by the Director of Nursing (DON) on 08/19/2020 at 12:13 p.m. The findings are: 1. Resident #3 had [DIAGNOSES REDACTED]. The Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 05/10/2020 documented the resident scored 15 (13-15 indicates cognitively intact) per a Brief Interview for Mental Status (BIMS). a. There was not a physician order [REDACTED]. There was no documentation in the care plan regarding the self-administration of medication. c. On 08/18/2020 at 8:52 a.m., Resident #3 was holding a medicine cup in her left hand and a spoon in her right hand. Resident #3 was asked, Are you self-administering your medicine? Resident #3 stated, Yes, I just finished. Resident #3 provided the medicine cup to Registered Nurse (RN) #1 who threw the medicine cup and spoon in the trash container. c. The Admission/(and or) Readmission Nursing Evaluations Packet contained a Self-Medication Assessment completed on 07/29/2020 documented, Does the resident WANT to self-administer his/ (or) her own medication? The assessment documented, No. and was signed on 07/29/2020. 2. Resident #5 had a [DIAGNOSES REDACTED]. The Admission MDS with an ARD of 05/14/2020 documented the resident scored 15 (13-15 indicates cognitively intact) per a BIMS. a. There is no documentation in the care plan regarding the self-administration of medication. b. On 08/18/2020 at 8:50 a.m., Resident #5 was holding a medicine cup with several pills in it. Resident #5 was asked, Are you self-administering your medication? Resident #5 stated, Yes, I can only take one pill at a time. c. The Admission/Readmission Nursing Evaluations Packet documented a Self-Medication Assessment completed 05/07/2020 documented, Does the resident WANT to self-administer his/her own medication? The assessment documented, No and was signed on 05/08/2020. 3. On 08/18/2020 at 9:29 a.m., Registered Nurse (RN) #2 was asked if Resident #3 or Resident #5 ever self-administered medication that she knew of and RN #2 stated, I have no knowledge of that, those are LPN #1's residents and she's at lunch now. 4. On 08/18/2020 at 12:00 p.m., LPN #1 was asked if she provided medication to Resident #3 and Resident #5 to self-administer? LPN #1 stated, For (Resident #5), yes. For (Resident #3) no, she took the last bite while I was in her room. LPN #1 was asked, Why was the medicine cup and spoon in her hand when I observed her? LPN #1 stated, We have to crush her medicine, I must have forgotten to get them. LPN #1 was asked, Where does the facility document a self-administration of medication assessment at? LPN #1 stated, We don't, we don't allow our residents to self-administer meds. 5. On 08/18/2020 at 1:08 p.m., RN #1 was asked, Does the facility have an assessment for the self-administration of medication? RN #1 stated, Yes it's located in the admission nursing evaluation assessment. 6. On 08/19/2020 at 10:08 a.m., the DON was asked, Should medication be left at bedside for residents to self-administer? The DON stated, Not without an assessment that designates it's safe. The DON was asked, Are you aware the answers to the question, do you want to self-administer medications was documented as no, so there is no assessment? The DON stated, Not until I was informed yesterday via text that we had a problem. I've already begun in-services and completed one on one counseling action. It just disappoints me because I've addressed and educated all staff over self-administration in March and again in April (2020).
F 0695 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide safe and appropriate respiratory care for a resident when needed.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Complaint (AR 293) was substantiated, all or in part, with deficiency cited at F695. Based on record review and interview the facility failed to ensure there was a physician order [REDACTED].#1 had [DIAGNOSES REDACTED]. The Quarterly Minimum Data Set with an Assessment Reference Date of 07/20/2020 documented the resident scored 11 (08-12 indicates moderately impaired) per a Brief Interview for Mental Status and Oxygen Therapy was indicated. a. A physician's orders [REDACTED]. b. As of 07/31/2020 when the resident was discharged , there was not a current order for oxygen therapy. c. The care plan documented, The resident has altered respiratory status / (and or) difficulty breathing r/t (related to) Chronic [MEDICAL CONDITION], Chronic Cor Pulmonae, Dyspnea, Hx (History) Of Sob, Chest Pain, Pneumonia, Respiratory Distress. Date Initiated: 04/24/2020 with the intervention to provide oxygen as ordered. d. Nurses notes dated from 07/07/2020 through 07/30/2020 documented the resident received oxygen therapy via nasal cannula. e. On 08/19/2020 at 10:08 a.m., the DON was asked, Do you recall (Resident #1)? The DON stated, Yes. The DON was asked, Why were there not orders for oxygen therapy in July (2020)? The DON stated, I don't know. The DON was asked, Should there have been orders for oxygen? The DON stated, Yes. The DON was asked, What should the oxygen order have contained? The DON stated, I don't write orders, but at a minimum liters per minute and parameters.
F 0842 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview the facility failed to ensure medical records were accurately documented and completed in accordance with accepted professional standards and practices related to one resident whose medicine was crushed (Resident #3) and for one resident (Resident #1) who used oxygen. The findings are: 1. Resident #1 had [DIAGNOSES REDACTED]. The Quarterly MDS with an ARD of 07/20/2020 documented the resident scored 11 (08-12 indicates moderately impaired) per a BIMS and Oxygen Therapy was indicated. a. A hospital note dated 04/19/2020 documented, On continuous home oxygen. b. The physician orders from 04/01/2020 to 08/2020 did not document any oxygen orders. c. The July 2020 nurse's notes documented oxygen was in use on the following dates: 07/30/2020 at 10:08 a.m., 07/28/2020 at 21:07 (9:07 p.m.), 07/25/2020 at 20:15 (8:15 p.m.), 07/24/2020 at 22:20 (10:20 p.m.), 07/21/2020 at 10:50 a.m., 07/20/2020 at 09:13 a.m., 07/18/2020 at 03:33 a.m., 07/14/2020 at 21:07 (9:07 p.m.), 07/13/2020 at 19:59 (7:59 p.m.), 07/10/2020 at 10:16 a.m., 07/07/2020 at 20:08 (8:08 p.m.), 07/03/2020 at 10:01 a.m., and 07/01/2020 at 20:11 (9:11 p.m.). 2. Resident #3 had [DIAGNOSES REDACTED]. The Quarterly MDS with an ARD of 05/10/2020 documented the resident scored 15 (12-15 indicates cognitively intact) per a BIMS and required a mechanically altered diet. a. As of 08/18/2020, there was no physician order to crush medication and place in food. b. On 08/18/2020 at 12:00p.m. Licensed Practical Nurse (LPN) #1 was asked if she provided medication to Resident #3 & Resident #5 to self-administer. LPN #1 stated, for Resident #5, yes, for Resident#3, no. She took the last bite while I was in her room. LPN #1 was asked, Why was the medicine cup and spoon in her hand when I observed her? LPN #1 stated, We have to crush her medicine, I must have forgotten to get them. c. On 08/19/2020 at 10:08 a.m., the DON was asked, Do you recall (Resident #1)? The DON stated, Yes. The DON was asked, Why were they're no orders for oxygen therapy in July (2020)? The DON stated, I don't know. The DON was asked, Should there have been orders for

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 0842 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 1) oxygen? The DON stated, Yes. The DON was asked, Should there be orders to crush medication and what to deliver it in? The DON stated, Yes. The DON was asked, Are you aware (Resident #3) doesn't have orders to crush her medication? The DON stated, I had to replace my medical records Licensed Practical Nurse just a couple months ago.