STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045170	A. BUILDING _____ B. WING _____	03/06/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
THE GREEN HOUSE COTTAGES OF BELLE MEADE	2200 CHATEAU BOULEVARD PARAGOULD, AR 72450

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F 0578 **Level of harm** - Potential for minimal 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 information regarding formulation of advanced directives was documented in a prominent part of the clinical record, to ensure the information was readily accessible to staff and facilitate their ability to follow residents' wishes for 3 (Residents #98, #114 and #101) of 24 (Residents #113, #325, #111, #46, 58, #107, #123, #88, #50, #105, #41, #101, #330, #35, #98, #47, #70, #114, #64, #115, #38, #69, #95) sampled residents whose clinical records were reviewed for advanced directive information. This failed practice had the potential to affect 8 residents who did not have an advance directive on file, as documented on a list provided by the Nurse Consultant on 3/5/2020 at 1:40 p.m. The findings are: 1. Resident #98 had [DIAGNOSES REDACTED]. The Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 01/29/2020 documented the resident scored a 5 (0-7 indicates severely impaired) on a Brief Interview for Mental Status (BIMS). a. On 3/3/2020 at 9:24 AM, there was no Do not Resuscitate (DNR) documentation found in the electronic medical record regarding an Advanced Directive. b. On 3/4/2020 at 9:30 AM, the Administrator was asked if this resident had an Advanced Directive. At 9:53 AM, the Administrator returned with the Advanced Directive signed 5/6/16. She stated, The Advanced Directive was not in the Electronic Record because they were completed a long time ago. His Advanced Directive was in the Financial Files. 2. Resident #114 had [DIAGNOSES REDACTED]. The Admission Quarterly MDS with an ARD documented the resident scored a 12 (8-12 indicates moderately impaired) on a Brief Interview for Mental Status (BIMS). b. On 3/3/2020 at 1:09 PM, the Resident was a Full Code. There was no documentation in medical record regarding an Advanced Directive. c. On 3/4/2020 at 9:30 AM, the Administrator was asked if this resident had an Advanced Directive. At 9:53 AM, the Administrator returned with an Advanced Directive signed 3/24/15 and she stated, This resident's Advanced Directive was not in her electronic record because it was completed a long time ago, it was in the financial file. 3. Resident #101 had a [DIAGNOSES REDACTED]. The Quarterly MDS with an ARD of 2/1/2020 documented the resident was severely impaired in cognitive skills for daily decision making per a Staff Assessment of Mental Status (SAMS). a. On 3/3/2020 at 10:05 a.m., there was no advance directive in the electronic clinical record. There was only a Do Not Resuscitate order dated 1/31/14. b. On 3/4/2020 at 8:30 a.m., the Administrator was asked if the facility could provide an advance directive. At 9:07 a.m. the Administrator provided a living will which documented advance directive wishes that was dated 1/31/14 which was located in the Business Office file.
F 0641 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure each resident receives an accurate assessment.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure the Minimum Data Set (MDS) Care Area Assessments (CAA) accurately reflected a further assessment of the triggered areas by looking for causal or confounding factors, some of which may be reversible to provide accurate information to develop a Care Plan to meet the residents' needs for 1 (Resident #70) of 23 (Residents #113, #325, #111, #46, 58, #107, #123, #88, #50, #105, #41, #101, #330, #35, #98, #47, #70, #114, #64, #115, #38, #69, and #95) sampled residents whose MDS assessments were reviewed. This failed practice had the potential to affect 24 residents as documented on the list provided by the Nurse Consultant on 3/4/2020 at 3:30 p.m. The findings are: Resident #70 had [DIAGNOSES REDACTED]. The Modified Admission MDS with an Assessment reference date of 10/1/19 documented the resident was severely impaired in cognitive skills for daily decision making per a Staff Assessment for Mental Status (SAMS); and had a fracture related to a fall in the 6 months prior to admission and an antidepressant medication was received 7 of the 7 look back period. a. An order dated 9/24/19 at 5:30 p.m. documented [MEDICATION NAME] HCl ([MEDICATION NAME])Tablet 100 MG (milligram) Give 1 tablet by mouth one time a day for depression. b. On 3/4/2020 at 1:21 p.m. the following Care Area Assessment (CAA's) were triggered and documented: 2. Cognitive Loss/Dementia Is this problem/need facilities response actual Nature of the problem/condition facilities response left blank. 4. Communication Is this problem/need facilities response potential Nature of the problem/condition facilities response left blank. 6. Urinary Incontinent and Indwelling Catheter Is this problem/need facilities response actual Nature of the problem/condition facilities response she is frequently incontinent of bowel. 7. Psychosocial Well-Being Is this problem/need facilities response actual Nature of the problem/condition facilities response left blank. 8. Mood State Is this problem/need facilities response actual Nature of the problem/condition facilities response left blank. 9. Behavioral Symptoms Is this problem/need facilities response actual Nature of the problem/condition facilities response left blank. 10. Activities Is this problem/need facilities response actual Nature of the problem/condition facilities response left blank. 11. Falls Is this problem/need facilities response actual Nature of the problem/condition facilities response left blank. 12. Nutritional Status Is this problem/need facilities response actual Nature of the problem/condition facilities response left blank. 15. Dental Care Is this problem/need facilities response actual Nature of the problem/condition facilities response she has upper and lower dentures, receives a mechanical soft diet. 16. Pressure Ulcer Is this problem/need facilities response actual Nature of the problem/condition facilities response left blank. 17. [MEDICAL CONDITION] Drug Use Is this problem/need facilities response actual Nature of the problem/condition facilities response left blank. 19. Pain Is this problem/need facilities response actual Nature of the problem/condition facilities response left blank. c. On 3/4/2020 at 2:03 p.m., the Administrator was asked, When did the Prospective Payment System (PPS) Assessment Coordinator (Licensed Practical Nurse (LPN) #4) leave? The Administrator stated, It was this past Sunday ([DATE]). The Administrator was asked, Did she have CAA training? The Nurse Consultant (NC) stated, Yes she did. The CAA documentation for R#70 was reviewed with the NC, who was then asked, were the further assessments on the CAA's completed by LPN #4? The Nurse Consultant stated, No. They were not worked.
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, record review, and interview the facility failed to ensure that a Comprehensive person-centered Care Plan was developed and implemented for 1 (Resident (R) #330) of 24 sampled residents. The findings are: R #330 had [DIAGNOSES REDACTED]. The Admission Minimum Data Set (MDS) documented the resident was Cognitive in Skills for Daily

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F 0656 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) Decision Making. a. A physician's orders [REDACTED]. b. The Care Plan dated 2/26/2020 did not contain any documentation of interventions relating to oxygen administration. c. On [DATE] at 1:30 PM, R #330 was lying in bed wearing a nasal cannula with tubing connected to the concentrator. The concentrator was on and the dial was set at 3 liters per minute. d. On 3/4/2020 at 2:10 PM, Licensed Practical Nurse (LPN) #3 (MDS Coordinator) was asked, Should oxygen administration be addressed in the Care Plan for residents on oxygen? She stated, Yes. She was asked, Is there a reason it is not addressed in the Care Plan for (R #330)? She stated, Yes. It should be in there. Our Medicare Person quit around the time she came in .I will make sure it's in there. e. On 3/4/2020 at 2:40 PM, the Assistant Director of Nursing (ADON) was asked, Who is responsible for monitoring the flow rates for residents receiving oxygen? She stated, The nurses are. She was asked, How is information about flow rates communicated? She stated, They pass information along in report. She was asked, Should oxygen administration be addressed in the Care Plan for residents on oxygen? She stated, Yes.
F 0661 **Level of harm -** Potential for minimal harm **Residents Affected -** Some	**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 that included a recapitulation of the resident's stay that consisted of a recapitulation of stay for 1 (Resident #89) of 1 sampled resident who was discharged in the past 90 days. This failed practice had the potential to affect 31 residents who were discharged in the past 90 days. The findings are: 1. Resident #89 had [DIAGNOSES REDACTED]. a. A Nurse note on 2/27/2020 at 2:46 p.m. documented Rt (resident) requested to discharge today with spouse instead of waiting until next week. Therapy and APN (Advance practice nurse) both ok with this. This worker met with both Rt and his spouse. Rt does not need any additional equipment as he has his own. Rt and spouse agreed to let us set them up with Home Health and Home Therapy services, as well as set him up with an office appt with his regular PCP (primary care physician). b. On 3/5/2020 at 9:04 a.m. a review of the Discharge plan contained the medication list, home health, and Doctor visit. It did not contain a recapitulation of stay, documented under summary of course of prior treatment, was nursing and therapy. At 9:08 the Administrator and the Nurse Consultant were asked if the recapitulation of stay was documented anywhere else? The Administrator stated, We'll look. At 9:20 a.m., the Administrator and the Nurse Consultant came into the room and stated, The discharge plan was all we have.
F 0677 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Provide care and assistance to perform activities of daily living for any resident who is unable.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interview, the facility failed to ensure male residents were regularly assisted with shaving, grooming of facial hair and resident's clothes were changed when they were visually soiled to ensure good grooming and hygiene for 1 (Resident #98) of 3 (Residents #38, #98 and #113) sampled resident who resided in Greenhouse #7 and were dependent for assistance with personal hygiene and grooming. This failed practice had the potential to affect 8 residents that resided in Greenhouse #7 as documented on a list provided by the Administrator on 3/5/2020 at 1:36 PM. The findings are: Resident #98 had [DIAGNOSES REDACTED]. The Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 1/29/2020 documented the resident scored a 5 (0-7 indicates severely impairment) on a Brief Interview for Mental Status (BIMS); and required limited to extensive assistance for Activities of Daily Living (ADLS). a. The Care Plan dated 1/29/2020 documented, Independent with most ADLS (Activities of Daily Living). Requires extensive assistance with toileting and dressing. At risk for decline due to chronic pain to his back. End stage Alzheimer's and [MEDICAL CONDITIONS]. I have episodes of incontinent to bowel and bladder. I prefer to sleep in my recliner. I require more support at times. Assist to and from bathroom, assist with transfer off and on toilet, assist with managing clothing and assist with peri care as needed. b. On [DATE] at 5:47 PM, Resident #98 was sitting in his recliner in his room with his daughter at his side. The resident's daughter stated, Dad's shirt is dirty and stained. It has dried stains on the front of his shirt in the chest area and lower left side. There is a brown dried substance on his left sleeve, and he needs a shave. A photograph was taken of the resident's shirt at his time. The resident's facial hair was unkempt A photograph of the resident's facial hair was taken at this time. The resident's daughter stated, Dad is supposed to get a shower twice a week and he gets a shave with his shower. I wasn't here yesterday so I don't know how long he has had that shirt on. If his clothes are soiled, they should change them even if it's not his shower day. I come in somedays like today and he's just sitting in the bathroom and no one checks on him. c. On 3/3/2020 at 1:40 PM, Certified Nursing Assistant (CNA) #22 was asked, How often does this resident gets a shower/bath and she stated, At least twice a week but some times he refuses. He did get a shower and a shave this morning. Sometimes if he refuses to let us do things for him the Hospice Nurse comes in twice a week and they can usually get him to do some things. d. On 3/4/2020 at 2:55 PM, the Assistant Director of Nursing (ADON) and the Nurse Consultant were asked, How much assistance does this resident need with ADLs? The ADON stated, I would say quite a bit now. He has had a significant decline. They were asked, Does the resident participate in his ADLs? She stated, He tries to participate. They were asked, Is assistance with ADLs provided in a timely manner, according to the resident's preferences and the care plan? The ADON stated, I would say yes as far I know. They were asked, Has the resident had a decline in his ability to independently perform any of his/her ADLs? The ADON stated, I would say yes. They were asked, Does resident ever refuse care? The ADON stated, He does sometimes. They were asked, When should the CNAs shave the resident? She stated, On shower days are whenever they ask for one or if they need one. They were asked, When should the resident's clothes be changed? The ADON stated, on Shower days, if his clothes are soiled or daily if needed. They are supposed to change their clothes between showers if they need it. e. On 3/5/2020 at 10:36 AM, CNA #23 was asked, Does this resident ever refuse care? He stated, Yes. He does every once in a while. He was asked, What do you do if he refuses care? He stated, I document it in the record and on paper and report it to the nurse in charge. He was asked, How much assistance do this resident require? He stated, Just one person. He was asked, How often does the resident get a shower/bath? He stated, Twice a week and whenever needed. Hospice come in and give him a bath sometimes. f. On 3/5/2020 at 10:48 AM, Licensed Practical Nurse (LPN) #7 (Green Educator) was asked, If a resident refuses care should it be care planned? She stated, Yes it should be care planned. g. On 3/5/2020 at 12:30 PM, the Nurse Consultant stated, We do not have a policy for ADL care but we do have an Orientation check off list for the CNA/Shabazm. The Administrator provided a copy of the Shabazim Orientation Checklist which listed shower, bed bath, Shaving and ADL's on it. She also provided a Licensed Nurse Orientation Checklist which documented under Resident Care: Resident Hygiene and grooming.
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 smoking materials were in place, as care planned, to decrease the potential for smoking-related injury for 1 (Resident (R) #46) of 2 (Residents #46 and #325) sampled residents who were care planned for smoking. This failed practice had the potential to affect 11 residents who were care planned for smoking, as documented on the list provided by the Administrator on [DATE] at 11:39 a.m. The findings are: Resident #46 had [DIAGNOSES REDACTED]. The Admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 6/10/19 documented the resident scored 11 (8-12 indicates moderately impaired) on a Brief Interview for Mental Status (BIMS); and uses tobacco. a. The smoking screen completed 9/3/19 documented .assessed to smoke safely unsupervised. Review quarterly and as indicated. Staff to keep lighter. b. The Care Plan dated 9/8/19 documented, .I wish to smoke and is designated as safe smoker with an intervention my lighter to be kept by staff and given to me as I need throughout day. c. On 3/3/2020 at 10:26 AM, R #46 pulled a lighter out of his pants pocket and lit a cigarette. At 1:13 p.m., R #46 pulled a lighter out of his pants pocket and lit his cigarette. d. On 3/3/2020 at 1:16 p.m., R #46 was asked, How long have you had that lighter in your pocket? He stated, About a week now. At 1:23 p.m., R #46 approached this surveyor and asked, Do I need to leave it (lighter) outside? This surveyor responded, It's not my decision to make. The resident stated, It's just been so cold they don't want to light when they've been left outside. e. On 3/3/2020 at 1:18 p.m., Licensed

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F 0689 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 2) Practical Nurse (LPN) #5 was asked, If residents were allowed to carry lighters on the persons? LPN #5 stated, Let me check. I don't know the answer to that question. At 1:20 p.m., LPN #5 came back in the room and stated, I talked to the Assistant Director of Nursing (ADON) who said no they are not. LPN #5 was asked, How long has she worked here (at the facility). LPN #5 stated, 3 years. f. On 3/3/2020 at 1:29 p.m., Certified Nursing Assistant (CNA) #21 was asked, how long had he had the lighter in his pocket? CNA #2 stated, From what I know if they have an assessment they can smoke whenever they want. He usually leaves it outside. g. On 3/3/2020 at 2:00 p.m., the Assistant Director of Nursing (ADON) was asked, When are staff trained on smoking policy and procedure? The ADON stated, Usually when they come into the house. The ADON was asked, And how often are smoking assessments supposed to be completed? The ADON stated, When they come in and quarterly. Nurse consultant identified residents were not allowed to keep lighters on their persons and would begin in-servicing staff.
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** Based on observation, record review, and interview the facility failed to ensure oxygen and updrafts equipment were dated and appropriately stored for 1 (Resident (R) #113) and oxygen was administered according to the flow rate in the physician order [REDACTED]. Resident #113 had [DIAGNOSES REDACTED]. The Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 2/4/2020 documented the resident scored 12 (8-12 indicates moderate impaired) and did not received oxygen therapy. a. The physician's orders [REDACTED]. Change oxygen tubing every week every night shifts every Sunday for [MEDICATION NAME]. b. The Care Plan dated 11/19/19 documented, I have [DIAGNOSES REDACTED]. Administer Oxygen and Updrafts as ordered. I may self-administer updraft treatments after it is set up by the nurse, the nurse is to measure solutions, store and clean machine. c. On [DATE] at 3:37 PM, Resident #113 had an Oxygen (O2) concentrator at his bedside with a humidifier bottle and bag hanging on the concentrator dated [DATE]20. The Oxygen tubing, nasal cannula nor the updraft mask were not dated. A photograph of the humidifier bottle and bag were taken at this time. An updraft machine was lying on the resident's bed with his updraft mask lying beside it. It was not in contained in a bag and it was not dated. A photograph of the updraft machine and mask were taken at this time. There was a bag lying in his recliner dated [DATE]20. d. On [DATE] at 4:44 PM, Licensed Practical Nurse (LPN) #8 was asked, Should the updraft mask be dated and be contained in a dated bag? She stated, Yes. It should be. She was asked, When are the O2 tubing, the humidifier bottle, and the bag changed? She stated, They should be changed and dated every Sunday night. e. On 3/4/2020 at 3:03 PM, the ADON was asked, How often should the Oxygen tubing and the updraft mask be changed out? The ADON stated, Once a week. 2. R #330 had [DIAGNOSES REDACTED]. The Admission Minimum Data Set (MDS) documented the resident was Cognitive in Skills for Daily Decision Making. a. A physician's orders [REDACTED]. b. The Care Plan dated 2/20/2020 was reviewed and no documentation was found relating to oxygen administration. c. On [DATE] at 1:30 PM, R #330 was lying in bed. She was wearing a nasal cannula with tubing connected to the concentrator. The concentrator was on and set at 3 liters per minute. d. On 3/3/2020 at 1:30 PM, Resident #330 was lying in bed and receiving oxygen at 3L via nasal cannula. The concentrator dial was on and set on 3L. Licensed Practical Nurse (LPN) #2 was approached and asked, How much oxygen should R #330 be receiving? She stated, I will have to check because I'm a float I don't work here all the time. She checked the orders on her laptop and stated, She gets 2L. She was asked to accompany surveyor to resident's room and check the setting on the concentrator. She checked the setting and stated, It's on 3L. I'll change it. She removed the storage bag that was hanging on the dial and adjusted the setting to 2L. She stated, This is not the concentrator that we normally use, it's one of the newer concentrators. It could be that the storage bag hanging on the dial had something to do with it (being on the wrong setting) because when I took the bag off the dial, it moved a little. She hung the storage bag on the back of the concentrator. She was asked, Who is responsible for monitoring the settings? She stated, The nurses are, but the Certified Nursing Assistants (CNAs) can tell us if they see a problem, they just can't touch it. She was asked, How is information on the ratings communicated between staff. She stated, In report. e. On 3/4/2020 at 2:10 PM, LPN #3 (MDS OBRA Coordinator) was asked, Should oxygen administration be addressed in the Care Plan for residents on oxygen? She stated, Yes. She was asked, Is there a reason it is not addressed in the Care Plan for R #330? She stated, Yes, it should be in there. Our Medicare Person quit around the time she came in .I will make sure it's in there. f. On 3/4/2020 at 2:40 PM, the Assistant Director of Nursing (ADON) was asked, Who is responsible for monitoring the flow rates for residents receiving oxygen? She stated, The nurses are. She was asked, Should oxygen administration be addressed in the Care Plan for residents on oxygen? She stated, Yes.
F 0761 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**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 upon observation and interview the facility failed to ensure that medications were not left at bedside to assure unintended residents did not have access to the medication. This failed practice had the potential to affect all twelve of the residents residing in Cottage 11 as documented on the list provided by the Administrator 3/5/2020 at 2:52 PM. The Findings are: Resident #95 had [DIAGNOSES REDACTED]. The Quarterly Minimum Data Set (MDS) with an Assessment Reference Date of 1/23/2020 documented the resident scored 10 (8-12 indicates moderately impaired) on a Brief Interview for Mental Status (BIMS). a. On [DATE] at 12:34 PM, Resident #95 was seated in a recliner in her room in Cottage 11. Medicine cups were on a small table next to the resident. One medication cup had a peach tablet and a green tablet in it. A second medication cup contained what appeared to be vanilla pudding with a plastic spoon in it. A photograph of the medication cups at this time. b. On [DATE] at 12:48 PM, Certified Nursing Assistant (CNA) #1 was asked, What is this? The CNA stated, TUMS and pudding probably. Maybe the nurse gave her some medicine. The CNA stated the nurse was Licensed Practical Nurse (LPN) #1 who was not currently in the building. c. On [DATE] at 1:27 PM, the nurse for Cottage 11, LPN #1 was shown the picture of the medication cups and asked what it was. Looks like chewable TUMS and pudding. I don't know if has a medicine in it or not. I didn't enter her room fully when I gave her meds (medications) earlier, so I didn't see it. I didn't give her those. LPN #1 was asked, Should they be at bedside. LPN stated No. They shouldn't be. Absolutely Not. d. On 3/4/2020 at 2:08 p.m., the Nurse Consultant was asked, Should medicine ever be left at bedside? The Nurse Consultant stated, No, never.
F 0803 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident.** Based on observation, record review, and interview the facility failed to ensure meals were prepared and served in accordance with the planned, written menu for preparation of mechanical consistency diets to meet the nutritional needs of the resident for 2 of 2 meal observed. This failed practice had the potential to affect 2 resident who received mechanical soft diet in cottage 5, 2 residents in cottage 3, 2 residents who received mechanical soft diet in 6, 1 resident who received mechanical soft diet in cottage 7, 1 residents who received mechanical soft diet in cottage 8 and 2 residents who received mechanical soft diet in cottage 9, according to a list provided by the Dietary Employee #1 on 3/3/2020. The findings are: 1. On [DATE] the facility Fall/Winter 2019-2020 menu for supper meal provided by the Administrator documented for the residents on mechanical soft diets were to receive breaded ground fish. On [DATE] at 4:55 p.m., Certified Nursing Assistant (CNA) #10 placed a serving of fish with cheese in a plate and cut it with a knife and served it to a resident who was on a mechanical soft diet. At 4:57 p.m., Certified Nursing Assistant #10 placed a serving of fish with cheese in a plate and cut it with a knife and served it to a resident who was on a mechanical soft diet. Certified Nursing Assistant #10 was immediately was asked, What was the reason the fish was not ground before serving it to the residents on mechanical soft diets? She stated, That's how we serve it; we cut it with knife. 2. On [DATE] the facility Fall/Winter 2019-2020 menu for noon meal provided by the Administrator documented for the residents on mechanical soft diets were to receive ground smothered pork chops. On 3/3/2020 at 12:03 p.m., the residents on mechanical soft diets were

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F 0803 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 3) served diced pork chops. The menu specified ground pork chops to be served to the residents on mechanical soft diets. On 3/3/2020 at 12:03 p.m., Certified Nursing Assistant #20 was asked, What was the reason residents on mechanical soft diets were not served ground meat? He stated, We pull the meat out and chop it as much as we can.
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.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the facility failed to ensure food items stored in the refrigerator, freezer and the storage areas were sealed or covered or used appropriate to maintain freshness and prevent potential cross contamination; expired food items were promptly removed form stock; staff washed their hands between dirty and clean tasks and before handling clean dishes or food items; failed to ensure staff completely covered their hair while assisting with the lunch meal service; temperature gauge probe was maintained in clean and sanitary condition to prevent potential for bacteria growth; 6 of 11 ice machines were maintained in clean and sanitary condition to prevent contamination of airborne particles, and hot foods were maintained at or above 135 degrees Fahrenheit on the counter while awaiting service and cold food items were 41 degrees or lower while awaiting service to prevent potential food borne illness for residents who received meals from 11 of 11 kitchens. These failed practices had the potential to affect 12 residents in cottage #1, 11 residents in cottage #2, 11 residents in cottage# 3, 10 residents in cottage 4, 7 residents in cottage 5, 12 residents in cottage #6, 11 residents in cottage #7, 11 residents in cottage # 8, 12 residents in cottage #9, 12 residents in cottage #10 and 12 residents in cottage 11 who received meals from 11 of 11 kitchens (Total Census: 123), as documented on a list dated [DATE] and provided by Administrator. The facility failed to ensure that staff did not touch a resident's food with ungloved hands for 1 (Resident (R) #47) of 4 (Residents #34, #47, #88, and #107) sampled residents who ate their meals in Cottage #6 (Hyde) dining room. The findings are: 1. Cottage 1: a. On [DATE] at 11:44 a.m., there was an open zip lock bag of ham was on a shelf in the in the storage room. The bag was not sealed. b. On [DATE] at11:47 a.m., the following observations were made in the storage room Freezer: 1) A bag of tarter tots was on a shelf in the freezer. The bag had date on it. 2) There was an open zip lock that contained garlic bread was on a shelf in the freezer. The bag was not sealed. 3) An open of breaded okra was on a shelf in the freezer. The bag was not sealed. 4) On [DATE] at 11:54 a.m., Certified Nursing Assistant #3 pushed a cart towards the ice machine. Without washing her hands, she picked up glasses by their rims and placed them on the cart and scooped ice cubes in the glasses to be served to the residents with their beverages for lunch. c. A half-gallon of cultured low-fat buttermilk on the shelf in the kitchen refrigerator in Cottage 1 had an expiration date of [DATE]. d. On [DATE] at 11:58 a.m., the temperatures of the food items when tested and read on the counter by Certified Nursing Assistant (CNA) #4 were with the following results: 1) Chili beans with sauce was 120 degrees Fahrenheit. 2) Corn was 121 degrees Fahrenheit. 3) Cream corn was 100 degrees Fahrenheit. 4) The above food items were not reheated before being served to the residents. 5) There was an open box of sugar free frosted oatmeal cookies on the counter. 2. Cottage # 11: a. On [DATE] at 12:06 p.m., there was a metal section inside of the ice machine in the storage room where ice touches before dropping to the ice collector had brown residue on it. Certified Nursing Assistant #5 was asked to wipe the brown residue inside on the metal inside the ice machine. She did so, and the residue easily transferred to the tissue paper. b. On [DATE] at 12:18 PM, there was an open zip lock bag of cheese was on a shelf in the refrigerator. The bag was not sealed. 3. Cottage #9: a. On [DATE] at 12:25 PM, there were 4 half gallons of cultured low-fat butter milk on the shelf in the refrigerator with an expiration date of [DATE]. Two gallons of milk were opened and some of the milk had been used from both gallons of milk. b. On [DATE] at 12:30 PM, the ice machine in the storage room had gray and black residue in the interior surfaces of the ice machine. Certified Nursing Assistant #6 was asked to wipe the black and gray residue in the interior surfaces of the ice machine. She did so, and the residue easily transferred to the tissue paper. Certified Nursing Assistant #6 was asked to describe the appearance of what were in the interior surfaces of the ice machine. She stated, They were black and gray residue. c. On [DATE] at 12:38 PM, there was an open plastic bag of ham on a shelf in the refrigerator. The bag was not sealed. A 5-lb container of sour cream was on a shelf in the refrigerator with an expiration date of [DATE]. 4. Cottage #8: a. On [DATE] at 12:44 PM. The following observations were made in the kitchen in cottage 8: 1) There was an open 24 ounce (0z) bag of dry crystals drink lemonade mix in the cabinet. The bag was not sealed. 2) A 16 0z box of corn starch was in the cabinet with an expiration date of [DATE]. 3) An open zip lock bag that contained 6 loose tea bags was in the cabinet. The bag was not sealed. 4) An open 24 0z bag of dry crystals fruit punch drink mix was in the cabinet in the kitchen. The bag was not sealed. 5. On [DATE] at 12:47 PM. The ice machine metal where ice touches before dropping to the ice collector had brown matter on it. Certified Nursing Assistant #7 was asked to wipe the brown residue on the metal of the ice machine. She did so, and the residue easily transferred to the tissue paper. She was asked to describe the contents on the metal. She stated, They were brown something. 6. A plastic bag on top of the ice machine where the ice scoop was stored had gray residue in it. Certified Nursing Assistant #7 was asked to describe the contents within the zip lock bag where ice scoop was stored. She stated, It was gray and sticky 7. On [DATE] at 12:55 PM the following observations were made in the refrigerator in the storage room: a. An open plastic bag of ham was on a shelf in the refrigerator. The bag was not sealed b. A zip lock bag that contained an open bag of roast beef was on a shelf in the refrigerator. The bag contained blood. There was no trace of blood in and out of the meat. The roast beef was discolored, was green in color and had four odors permeating from it. The bag documented best used or freeze by [DATE]. Certified Nursing Assistant #7 was asked to describe the appearance of roast beef. She stated, It was green and had foul odors. c. An open zip lock bag that contained 3 blocks of white cheese with an open date of [DATE] was on the shelf in the refrigerator. The bag was not sealed. d. An open bag of yellow cheese was on a shelf in the refrigerator. The bag was not sealed. e. An open bag of chicken strips was on a shelf in the freezer. The bag was not sealed. f. An open zip lock bag of ham was on a shelf in the refrigerator. The bag was not sealed. 8. On [DATE] at 5:19 PM, Certified Nursing Assistant #19 was wearing gloves on her hands, she turned on the water faucet, rinsed the temperature gauge stem, turned off the water faucet, and wiped the temperature gauge stem with contaminated glove. She was asked, What should you have done after touching a dirty object before handling any clean object? She was also asked, How should you have cleaned the temperature gauge? She stated, Removed my gloves, washed my hands with soap and water, and cleaned the gauge. 9. Cottage #7: a. On [DATE] at 1:12 PM, the following observations were made in the kitchen in cottage 7: 1) A 16-oz box of baking soda was in the cabinet. The box was not covered. 2) The ice machine metal where ice touches before dropping to the ice collector had brown matter on it. Certified Nursing Assistant #8 was asked to wipe the brown residue on the metal of the ice machine. She did so, and the residue easily transferred to the tissue paper. She was asked to describe the contents on the metal. She stated, They were brown residue. She was asked, How often is the ice machine cleaned? She stated, The night shift cleans it two times a week. She was asked, Who uses ice from the machine? She stated, They use it to fill beverages for the residents at mealtimes. They also use it to fill the resident water pitchers. 3) On [DATE] at 4:52 PM, Certified Nursing Assistant #17 and Certified Nursing Assistant #18 had placed hairnets on their heads in a manner that not fully cover their hair. They had approximately ,[DATE] inches of hair exposed from the back of neck and hanging from both sides. b. On [DATE] at 1:30 PM, a plastic bag that contained roast beef was on a shelf in the refrigerator. The manufacturer's specification was to use or freeze by [DATE]. The CNA #8 stated, It has expired. 10. Cottage #6 a. On [DATE] at 1:40 PM, the following observations were made in the kitchen in cottage 6: 1) There was a 16-oz box of corn starch was in the cabinet. The box documented, .best by [DATE] . 2) An open plastic bag of corn meal was on the shelf in the storage room. The bag was not sealed. 3) On [DATE] at 1:50 PM, there was an opened ,[DATE]-gallon of cultured low-fat buttermilk on the shelf in the upright refrigerator with an expiration date of [DATE]. c. On [DATE] at 4:59 PM, Certified Nursing Assistant #12 was wearing gloves on her hands when she touched the wet rag that was on the table and without changing gloves and washing her hands, she used her gloved hand to hold up the fish to test the temperature. At 5:01 PM after testing the food temperature she wiped her gloved hand on the rag then ground 3 servings of fish patties that were in the blender. She used her contaminated gloved hand to scoop the fish out of the blender into a bowl. The temperature of the ground fish was 132 degrees F. 11. Cottage #5 a. On [DATE] at 1:53 PM, the following observations were made in the kitchen in cottage 5: 1) There was an opened box of corn starch in the cabinet that was not covered. 2) There was an opened plastic bag that contained 10 loose bags of tea in the cabinet. The Certified Nursing Assistant #10 took a marker out of her pocket and then put it back in her pocket. Without washing her hands, she touched the tea bags as she was counting. 3) On [DATE] at 4:49 PM, Certified Nursing Assistant #10 had placed her hairnet in a

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	045170	A. BUILDING _____ B. WING _____	03/06/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
THE GREEN HOUSE COTTAGES OF BELLE MEADE	2200 CHATEAU BOULEVARD PARAGOULD, AR 72450

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 0812 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	(continued... from page 4) manner that not fully cover all her the hair and had approximately 2 inches of hair exposed from the back of neck and hanging from both sides. 4) The food items when tested by Certified Nursing Assistant #10 in bowls on the table were with the following results: fish with cheese was 122.7 degrees Fahrenheit and mashed potatoes was 119 degrees Fahrenheit. 12. Cottage #4 a. On [DATE] at 2:17 PM, the following observations were made in the kitchen in cottage 4: 1) There was a 16-oz box of baking soda with an expiration date of [DATE] in the cabinet. 2) There was another unsealed 16-oz box of baking soda in the cabinet. 3) There were 2 gallons of cultured low-fat butter milk with a use-by date of [DATE]. 4) There were 2 open bags of pork fritters in the freezer and an opened plastic bag of garlic bread. 5) There was an opened plastic bag of mozzarella cheese on a shelf in the refrigerator. 6) A plastic bag that contained roast beef was on a shelf in the refrigerator. The manufacturer's specification was to use or freeze by [DATE]. The Certified Nursing Assistant #13 stated, It has expired. 7) There was a 5-pound container of sour cream with expiration date of [DATE]. 8) On [DATE] at 2:32 PM, the ice machine spout had a reddish residue. Certified Nursing Assistant #13 was asked to wipe the residue in the spout. She did so, and the residue easily transferred to the washcloth. She was asked to describe the contents on the washcloth. She stated, It was a reddish, blackish-like color. She was asked, How often is the ice machine cleaned? She stated, Every Sunday. She was asked, Who uses ice from the machine? She stated, They use it to fill beverages served to the residents at mealtimes. They also use it to fill the resident water pitchers. 13. Cottage #3 a. On [DATE] at 2:39 PM, the following observations were made rounds in the kitchen. 1) There was an open bottle of lime juice in a cabinet. The label on the bottle documented, refrigerate after opening. 2) The was an open, partially used bottle of lemon juice in the kitchen cabinet. The manufacturer's instructions on the bottle documented, refrigerate after opening. 3) There was a box of Buttermilk Pancake and Waffle on the counter. The box was not covered. Certified Nursing Assistant # 14 stated, I used it this morning. 4) There was a 16-oz bottle of baking soda in the cabinet. The box was not covered. 5) There was a 32-oz bottle of light corn syrup in the cabinet with no opened date. 6) An 18.3-oz box of fudge brownie deluxe mix was open in the cabinet. 7) An open bag of yellow cornbread mix was on a shelf in the storage room. 8) There were 3 packages of saltine crackers that were unsealed on the shelf. 9) There was an open bag of chicken tenders on a shelf in the freezer. 10) There was an opened zip-lock bag of yellow cheese on the shelf in the refrigerator. 11) A zip-lock bag that contained roast beef was on a shelf in the refrigerator. The manufacturer's specification was to use or freeze by [DATE]. The Certified Nursing Assistant #14 stated, It has expired. I will toss it. 12) On [DATE] at 4:43 PM, Certified Nursing Assistant #16 touched the recipe book with her bare hand contaminated her hand then at 4:44 PM without washing her hand she picked up a clean blade and attached it to the base of the blender to be used in pureeing food to be served to the residents. At 4:45 PM, she placed fish into the blender added tarter sauced and pureed the contents and poured the pureed fish into a crockpot. She placed her hairnet placed in a manner that not fully cover her hair and had approximately 2 inches of hair exposed from the back of her neck. 13) On [DATE] at 5:03 PM, the temperatures of the food items when tested by Certified Nursing Assistant #16 on the counter, the pureed fish was 112.9 degrees Fahrenheit. 14. Cottage #2 a. On [DATE] at 3:03 PM, the following observations were made in the kitchen in cottage 2: 1) There was a 16-oz bottle of baking soda was in the cabinet. The box was not covered. 2) There was an open, undated bag of chocolate cookie dough on a shelf in the freezer and a plastic bag of opened, undated biscuits. 3) There was an opened plastic bag of yellow American cheese on the shelf in the refrigerator. 4) An opened plastic bag that contained ham was on a shelf in the refrigerator. 5) The refrigerator in the kitchen had a bag of cheese cubes that was unsealed. 15. Cottage 10: a. On [DATE] at 03:25 PM, the following observations were made in the kitchen in cottage 10: 1) An open plastic bag of turkey ham was on a shelf in the refrigerator. The bag was not sealed 2) A plastic bag that contained roast beef was on a shelf in the refrigerator. The manufacturer's specification was to use or freeze by [DATE]. The Certified Nursing Assistant #15 stated, It has expired. I will toss it. 3) A 28 0z box of cream of wheat was in a cabinet. The box was not covered. 4) A 16 0z box of cornstarch was in a cabinet. The box was not covered. 5) Another 16 0z box of cornstarch was in a cabinet with an expiration date of [DATE]. 6) An open bag of hush puppies was on a shelf in the refrigerator. The bag was not sealed. 16. Resident #47 had [DIAGNOSES REDACTED]. a. On [DATE] at 5:14 PM, during the dinner meal observation, Certified Nursing Assistant (CNA) #12 used ungloved hands to cut a ham sandwich in half for R #47. She placed her ungloved left hand on top of the sandwich to hold it in place while cutting it into with her ungloved right hand. b. On [DATE] at 5:35 PM, Certified Nursing Assistant (CNA) #12 was asked, Is it ever appropriate to touch a resident's food with ungloved hands? She stated, No, She was asked, Should you have placed your ungloved hand on R #47's sandwich while you were cutting it? She stated, No. Did she say she don't want it now. I can get her another one? She was asked, How should you have handled the sandwich while cutting it? She stated, I should have put gloves on. I'm sorry. I just wasn't thinking. She was asked, Did you receive training on proper handling of food? She stated, Yes. c. On [DATE] at 1:36 PM, CNA #9 was asked, Is it ever appropriate to touch a resident's food with ungloved hands? She stated, No. She was asked, How should you handle slicing or cutting food for a resident? She stated, First I would wash my hands and put on glove and then cut it. d. On [DATE] at 3:00 PM, a form titled Single-Use Gloves provided by the ADON documented, .Used properly, they (single-use gloves) can help keep food safe by creating a barrier between hands and food .Single-use gloves should always be worn when handling ready-to-eat food .
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 staff had Personal Protective Equipment (PPE) available for 1 (Resident (R) #330) of 1 sampled resident who was on isolation, and staff washed their hands during medication administration. These failed practices had the potential to affect all 123 residents as documented on the Resident Census and Conditions of Residents Form provided by the Administrator on [DATE] at 5:40 p.m. The findings are: 1. R #330 had [DIAGNOSES REDACTED]. The Admission Minimum Data Set (MDS) documented the resident was cognitive in skills for daily decision making. a. The Order Summary report dated (NAME)4, 2020 documented, she was on contact isolation for infectious bacteria in the urine (ESBL or Extended Spectrum Beta-Lactamase). b. On [DATE] at 1:11 AM, during initial rounds, a contract representative was waiting outside R #330's room. He stated he was waiting for staff to provide him with an isolation gown so he could enter the resident's room and perform an electrocardiogram (EKG) on her. Certified Nursing Assistant (CNA) #24 arrived at approximately 1:16 PM with isolation gowns. She was asked, Should Personal Protective Equipment (PPE) always be available outside the resident's room? She stated, Yes. But we ran out. She was asked, Where did you have to go to get the gowns? She stated, To another cottage. She was asked, Do you have a storage room in this cottage? She stated, Yes. She was asked, Whose responsibility is it to keep the equipment stocked? She stated, The CNAs. c. On 3/30/2020 at 1:12 PM, there were no isolation gowns in the bin outside the resident's room. Licensed Practical Nurse (LPN) # 2 was asked, Should appropriate PPE always be available outside the rooms of residents on isolation? She stated, Yes. I will get some from the supply closet. She searched the storage room and was unable to find gowns. A CNA was sent to another cottage to obtain gowns. She was asked, What would be the consequences if the resident required emergent care and no gowns were available? She stated, That would not be good. She was asked, Whose responsibility is it to monitor and restock the PPE bin? She stated, The CNAs, but we can all help when we see it needs restocking. She was asked, Is there a reason there are no gowns in the supply closet? She stated, I think it's because there's a shortage, so we have to go to the administration building or get some from other cottages. c. On 3/4/2020 at 2:40 PM, the ADON was asked, Should appropriate PPE always be available outside the rooms of residents on isolation? She stated, Yes. She was asked, Is there a reason why isolation gowns were not available for (R #330) on two separate occasions when I made rounds? She stated, Our gowns are on back order. Our supplier sent us a notice saying they're short on supplies because of the Coronavirus. She was asked, How many residents do you have on isolation? She stated, I think about three. She was asked, How many cottages do you have? She stated, 11. She was asked, Do you have isolation gowns in each of those supply closets? She stated, Yes. We should. The Nurse Consultant was present and stated, We are going to fix it by moving gowns from the other cottages and putting them in the cottages where we need them. d. On 3/5/2020 at 10:47 AM, a policy titled Transmission Based Precautions Categories provided by the Administrator documented, .Purpose: To prevent transmission of infections or colonized microorganisms .Policy: Transmission-Based Isolation Precautions have been established to ensure that appropriate techniques are implemented in this facility when necessary .Contact Precautions: Donning PPE upon room entry and discarding before exiting the patient room is done to contain pathogens .

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	045170	A. BUILDING _____ B. WING _____	**03/06/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
THE GREEN HOUSE COTTAGES OF BELLE MEADE	**2200 CHATEAU BOULEVARD PARAGOULD, AR 72450**

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

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F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 5) 2. On 3/3/2020 at 10:46 AM, during observation of the Medication Administration, Licensed Practical Nurse (LPN) #1was pushing her computer cart to administer medications to a resident. During this time, LPN #1 came from inside of the medication room down the hallway, touching her computer and rolling the cart. When LPN#1 made it to the resident's doorway she unlocked the individual's medication cabinet in her room and retrieved the resident's medications that were being given at the time. LPN #1 touched the resident's door and started popping the medication's out of the cards after the surveyor reviewed the medications to be administered. LPN #1 grabbed 2 empty cups from the inside rim of the cups, one cup to place water in to rinse resident's mouth after giving the resident her inhaler, and the other glass was to spit in after rinsing her mouth out from the residual of the inhaler. a. On 3/3/2020 at 10:49 AM, LPN #1 was asked, When should you sanitize your hands when administering medications? LPN #1 stated, Prior to administering the medications and in between each resident. She was asked, Do you usually sanitize hands while passing medications to other residents? LPN #1 stated, Yes. I just forgot to do that this time. She was asked, What could this cause? LPN #1 stated, It could spread germs to other residents. b. On 3/5/2020 the Nurse Consult provided a list on Hand Hygiene, which documented, .Perform Hand Hygiene When: before having direct contact with patients, after contact with blood, body fluids, or excretions, mucus membranes, non-intact skin, or wound dressing; after contact with patient's intact skin,; if hands will be moving from a contaminated-body site to clean-body site during patient care; after contact with inanimate objects in immediate vicinity of the patient; after removing gloves .