STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045369	A. BUILDING _____ B. WING _____	08/06/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MOUNTAIN MEADOWS HEALTH AND REHABILITATION	1680 BATESVILLE BOULEVARD 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 0684 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**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, record review and interview, the facility failed to ensure a resident's pain was assessed in a timely manner for 1 (Resident #2) who experienced pain. This failed practice had the potential to affect 93 residents that resided in the facility, according to The Resident Census and Conditions of Residents. The findings are: 1. Resident # 2 had [DIAGNOSES REDACTED]. A Quarterly Minimum Data Set with an Assessment Reference Date of 06/23/2020 documented the resident scored 15 (13-15 indicates cognitively intact) on a Brief Interview for Mental Status and required total care of 2 person extensive assist for transferring and incontinent care. a. An OLTC (Office of Long Term Care) Form 762 dated 08/05/2020 documented, I had (Resident #2) ready to transfer and his wheelchair in position with the wheels locked. As he grabbed for the wheelchair to stand his self the wheelchair rolled away. I did all I could to catch him and I was able to lower him to the ground. He did not fall whatsoever . b. On 08/06/2020 at 8:00 a.m., Resident #2 was lying in bed. Certified Nursing Assistants (CNA)#1 and # 2 provided incontinent care to the resident. They removed the pillows from under the resident's body. Resident #2 stated, Oh, my legs are hurting, they dropped me yesterday. CNA #1 stated, Yeah, they dropped him yesterday. Resident #2 pointed to his right knee and stated, I think they broke my right leg. My leg is still hurting. I could hardly get any sleep last night. I told the nurse last night that I was hurting, but it didn't do any good. It hurts, they dropped me. The nurse gave me Tylenol, about 2hours after I asked for it. He was asked, Did they x-ray your leg yesterday? He stated, No, but I think they should have. CNA #1 and #2 continued to remove his clothing. The resident stated, Oh, my leg hurts. Those CNA's rolled that wheelchair from up under me. I hit the floor. He stated to the CNA's, Be really careful. CNA #1 and #2 continued to undress the resident and he yelled out, Oh, Oh, you're moving that leg again. CNA #1 and #2 continued removing clothing and provided incontinent care. The resident continued to yell out, I wish y'all hurry up and get me up. My right knee is killing me. c. On 08/06/2020 at 8:15 a.m., CNA #1stopped providing incontinent care and stated, I'm going to get the nurse, cover him up. She exited the room. CNA #1 approached Licensed Practical Nurse (LPN #1) and stated, He is in pain. LPN #1 yelled out, He had one this morning. Per the Medication Administration Record [REDACTED]. CNA #1 whispered something to her. CNA #1 entered the resident room. CNA #1 and #2 continued with incontinent care for the resident. The resident was repeatedly yelling, My knee is killing me. d. On 08/06/2020 at 8:20 a.m., RN #1 entered the resident's room and stood behind the door. She stated, I'm going to talk with him. I'll be back once they are done providing care. RN#1 exited the room without assessing the resident. Staff continued providing incontinent care. The resident lifted his right hand to CNA #1 and stated, Y'all get ready, you are hurting my leg. CNA #1 stated, We'll be as tender as can be. Both CNA's rolled the resident from right to left. He was yelling out, Oh God, your hurting my knee. He hits the bed with his fist. CNA #1 stated, Thank you for being patient with me. e. On 08/06/2020 at 8:25 a.m., LPN #1 was asked, Was it reported to you that (Resident #2) was in pain. She stated, Yes. The Director of Nursing (DON) was asked, When the CNA's are providing care to a resident and they are yelling out in pain, what should the CNA's do? She stated, Immediately report it to the nurse. The DON was asked, What should the nurse do? The DON stated, Go assess the resident and call the doctor. The DON was informed the resident was yelling out in pain during incontinent care and had been reported to 2 nurses. The resident was not assessed. The DON stated, The CNA's should have immediately stopped care. f. On 08/06/2020 at 8:40 a.m., RN #1 entered (Resident #2's) room and stated, The APN (Advanced Practice Nurse) is ordering an x-ray. CNA #1 continued to provide incontinent care to Resident #2. He yelled out, Oh, Oh, y'all hurting my knee. The DON then stated, Y'all take a break for now. g. On 08/06/2020 at 8:45 a.m., CNA #1 and #2 started providing incontinent to the resident. The DON stated, Let me look at his knee. The DON raised his right leg. Resident #2 raised his right hand, and yelled out, Oh, you are killing my knee. The DON immediately stopped assessing his knee. The resident's right knee was larger than his left knee. There was no skin discoloration or protruding bones. The DON was asked, What happened to his knee? The DON stated, He fell yesterday. h. On 08/06/2020 at 9:30 a.m., CNA #3 was asked to explain how the fall occurred yesterday during the resident transfer. He stated, I transferred him like always. CNA #3 was asked, How many staff transferred the resident? He stated, One, no one else was in the room when I transferred him. He didn't fall I lowered him to the floor and went and got the nurse. He was asked, What did the nurse do? He stated, She looked him over. He said he was okay. .I went and got two other CNA's to help get him off the floor. He was asked, How was the resident positioned before and after the fall? He stated, I lowered him on his butt. He was asked, How many people are required to transfer the resident? CNA #1 stated, I transfer him one or two person extensive assist. I stood him up, the wheelchair was locked, but it still rolled back. There was something wrong with the locks on the wheelchair. I think it was reported to maintenance. i. On 08/06/2020 at 10:55 a.m., CNA #1 was asked, How did Resident #2's fall occur on 08/05/2020? CNA #1 stated, I wasn't present in the room when the fall occurred, but from word of mouth 2 aides dropped him during a transfer. She was asked, If a resident hollers out in pain during incontinent care what should you do? CNA #1 stated, Stop immediately and go get the nurse. She was asked, Did you immediately stop incontinent care and go get the nurse? She stated, No. She was asked, When you report a resident's pain to a nurse and the nurse doesn't assess the resident in a timely manner, what should you do? She stated, Report it the supervisor on the floor. She was asked, Did you report the resident's pain to the nurse. She stated, Yes, she told me she would look and see when was the last time he received the pain medication. I told LPN # 1 he was hurting. She did nothing, that's why I told the nurse supervisor. j. On 08/06//2020 at 11:06 a.m., LPN #1 was asked, What should you do if a CNA reports that a resident is in pain? She stated, I go assess them and find out what's bothering them. She was asked, How soon should you assess the resident? She stated, Immediately. She was asked, How soon did you go check on (Resident #2)? LPN #1 stated, I didn't go check on him. I guess I could have. k. On 08/06/2020 at 11:14 a.m., RN#1 was asked, What should you do if a CNA reports that a resident is in pain? She stated, I go and assess the resident and ask the nurse on duty what type of pain medication he had prescribed. I would absolutely, immediately assess the resident. RN #1 did not assess the resident's pain or condition of his right knee.
F 0686 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide appropriate pressure ulcer care and prevent new ulcers from developing.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interview, the facility failed to ensure residents linen remained free of soilage in order to prevent skin break down for 2 (Resident #2 and #4) of 4 (Residents #1, #2, #3 and #4) case mix residents who were at risk for potential skin break down. This failed practice had the potential to affect 93 residents who were receiving preventive skin care as documented on the Resident Census and Conditions of Residents provided by the Administrator on 08/06/2020. The findings are: 1. Resident # 2 had [DIAGNOSES REDACTED]. A Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 06/23/2020 documented the resident scored 15 (13-15 indicates cognitively intact) per a Brief Interview for Mental Status (BIMS) and required extensive assistance of 2 people for transferring and

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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MOUNTAIN MEADOWS HEALTH AND REHABILITATION	**1680 BATESVILLE BOULEVARD BATESVILLE, AR 72501**

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F 0686 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 1) incontinent care, was at risk for pressure ulcers and had Moisture-Associated Skin Damage a. On 08/06/2020 At 8:45 a.m., Certified Nursing Assistant's (CNA) #1 and #2 were providing incontinent care to Resident #2. CNA #1 rolled the resident to the left. There was a large stain outlined with brown on the white fitted sheet. CNA #1 was asked, What kind of stain is that on his sheet? She stated, It's a brown stain and it appears to be dry. That is not good. She was asked, Why is that not good? CNA #1 stated, Looks like he didn't get changed last night or they were late changing him. CNA #1 and #2 dressed the resident and transferred him to his wheelchair. The white fitted sheet had a large wide brown stain from the mid-section to the lower section of the bed. CNA #1 and #2 removed the bed linen from the bed and there was a large stained area on the mattress. 2. Resident #4 had [DIAGNOSES REDACTED]. A Quarterly MDS with an ARD of 05/25/2020 documented the resident scored 13 (13-15 indicates cognitively intact) per a Brief Interview for Mental Status (BIMS) and was frequently incontinent of urine and occasionally incontinent of bowel and was at risk for pressure ulcers. a. On 08/06/2020 at 7:40 a.m., Certified Nursing Assistant #4 was changing the linen on Resident #4's bed. A large stain outlined with brown was on the white fitted sheet. She removed the fitted sheet from the bed and a large stain was on the resident's mattress. CNA #4 placed a clean white fitted sheet on the resident's stained mattress. CNA #4 was asked, What is the stain on the sheets and mattress? CNA #4 stated, He was wet, and it came through his brief and saturated the bed. She was asked, Where is the brief that you removed this morning? She reached into a clear bag that was on the floor and removed a white brief that was saturated with yellow urine from the bag. CNA #4 was asked, Should you place clean linen on a soiled mattress. CNA #4 stated, No, I should clean the mattress first.
F 0689 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**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** Complaint (AR 834) was substantiated, all or in part, with a deficiency cited at F689 Based on observation , record review and interview, the facility failed to ensure transfers were conducted as per the plan of care to decrease the potential for injury for 1 (Resident #2) of 3 (Residents #1 ,#2,and #4) case mix residents who were dependent on staff for a 2 person extensive assist with transfers. This failed practice had the potential to affect 37 residents who were dependent on a 2 person extensive assist according to a list provided by the Administrator (DON) on 08/06/2020. The findings are: 1. Resident #2 had [DIAGNOSES REDACTED]. A Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 06/23/2020 documented the resident scored 15 (13-15 indicates cognitively intact) per a Brief Interview for Mental Status (BIMS) and required total care of 2 person extensive assist for transferring and incontinent care. a. An OLTC (Office of Long Term Care) Form 762 dated 08/05/2020 documented, I had (Resident #2) ready to transfer and his wheelchair in position with the wheels locked. As he grabbed for the wheelchair to stand his self the wheelchair rolled away. I did all I could to catch him and I was able to lower him to the ground. He did not fall whatsoever . b. On 08/06/2020 at 8:00 a.m., Certified Nursing Assistant (CNA) #1 and # 2 provided incontinent care to Resident #2. They removed pillows from under the resident's body. Resident # 2 stated, Oh, my legs are hurting, they dropped me yesterday. CNA #1 stated, Yeah, they dropped him yesterday. Resident #2 stated, I think they broke my right leg. My leg is still hurting. I could hardly get any sleep last night. I told the nurse last night that I was hurting, but it didn't do any good. It hurts, they dropped me. The nurse gave me Tylenol, about 2 hours after I asked for it. He was asked, Did they x-ray your leg yesterday? He stated, No, but I think they should have. CNA #1 and #2 continued to remove his clothing. The resident stated, On my leg hurts. Those CNA's rolled that wheelchair from up under me, I hit the floor. He was asked how many CNA's were present during your transfer? He stated, It may had been 2 or 3, and they were just standing around looking. c. On 08/06/2020 At 9:30 a.m., CNA #3 was asked to explain how the fall occurred yesterday during the (Resident #2) transfer. He stated, I transferred him like always. CNA #3 was asked, How many staff transferred the resident? He stated, One, no one else was in the room when I transferred him. He didn't fall I lowered him to the floor and went and got the nurse. He was asked, What did the nurse do? He stated, She looked him over. He said he was okay . I went and got two other CNA's to help get him off the floor. He was asked, How was the resident positioned before and after the fall? He stated, I lowered him on his butt. He was asked, How many people are required to transfer the resident? CNA #3 stated, I transfer him one or two person extensive assist. I stood him up, the wheelchair was locked, but it still rolled back. There was something wrong with the locks on the wheelchair. I think it was reported to maintenance. d. On 08/06/2020 at 9:55 a.m., the Director of Maintenance (DOM) was asked, How often are the residents' wheelchairs maintenance, was a logged kept, and how is he notified of malfunctioning wheelchairs? The DOM stated, There is a report log sheet that hangs on the outside door of the maintenance office. We try to get staff to right down repairs on the log, but they mostly just tell me in passing. When I came in yesterday, I was told the resident had a fall and I needed to look at the resident's wheelchair brakes. I tighten up the brakes, the anti-roll backs were fine. He was asked, How often are the wheelchairs serviced? He stated, It's not a scheduled thing. Our guy quit and we are in the process of hiring another maintenance guy now. He is in orientation. He was asked if the resident wheelchair brakes had malfunctioned in the past? He stated, No. The report log did not contain documentation of Resident #2's wheelchair was malfunctioning.