STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045346	A. BUILDING _____ B. WING _____	07/24/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
DIERKS HEALTH & REHAB	402 S ARKANSAS AVENUE DIERKS, AR 71833

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F 0637 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Assess the resident when there is a significant change in condition** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview the facility failed to ensure a resident who had a decline in 2 or more areas of activities of daily living had a Significant Change Minimum Data Set (MDS) to ensure accuracy and the development of an appropriate plan of care for 1 (Resident #13) sampled resident. This failed practice had the potential to affect all 49 residents based on the Resident's Census and Condition of Residents provided by the Administrator on 07/14/2020. The findings are: Resident #13 had [DIAGNOSES REDACTED]. An Annual MDS with an Assessment Reference Date of 04/22/2020 documented the resident scored 13 (13-15 indicates cognitively intact) per a Brief Interview of Mental Status and required supervision with bed mobility, transfers, walking, locomotion, personal hygiene; limited assistance with dressing, toileting; independent with eating and required physical assistance with bathing. a. On 07/14/2020 at 08:45 P.M., a comparison of the Annual MDS with an ARD of 04/22/2020 and a Discharge MDS with an ARD of 12/31/2019 showed the resident had a decline in bathing, dressing and toilet use. The resident had a Discharge MDS with ARD of 02/20/2020 and one on 03/04/2020. A 5- day MDS with ARD of 03/14/2020 documented an improvement in 7 areas of ADL and 1 decline of ADL. b. On 07/16/2020 at 11:40 A.M., the MDS Coordinator was asked the criteria for doing a significant change MDS. She stated, If they have a significant change in Activities of Daily Living, and changes to hospice services. He (Resident #13) participated in Physical Therapy and made improvements. He is back ambulating. He was in a wheelchair. She was asked if a Significant Change MDS should have been done for Resident #13. She stated, I tried to capture the changes on the 5-day (MDS). I refer to the consultant and go with her (go with her advice). She was asked if he had had a decline in more than two areas of ADL's. She stated, Not that I am aware of, but I can follow up on that in the future. I think the only sig (significant) changes I've done is with hospice or palliative care. c. On 07/16/2020 3:36 P.M., the Administrator was asked the criteria for doing a significant change MDS. She stated, I do know if there are two or more areas of decline in ADLs and if they go or come off of hospice (a significant change MDS would be done).
F 0693 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interview, the facility failed to ensure physician's order were followed for a free water flush before and after bolus feeding through a Percutaneous Endoscopic Gastrostomy (PEG) tube for 1 (Resident #25) resident. This failed practice had the potential to affect 2 residents who received nutrition and fluids via a feeding tube, as documented on the Roster Matrix that was provided by the Director of Nursing on 07/13/2020 at 1:52 P.M. The findings are: Resident #25 had a [DIAGNOSES REDACTED]. a. A Care Plan dated 06/08/2020 documented, . has potential fluid deficit r/t (related to) NPO (nothing by mouth), all feedings / (and or) liquids consumed through feeding tube. O. . will be free of symptoms of dehydration and maintain moist mucous membranes, good skin turgor . b. A Physician's Order dated 06/17/2020 documented, . [MEDICATION NAME] @ (at) 50mls/hr (milliliters per hour) for 14 hours 6 p.m. to 8 a.m. Day time bolus feedings [MEDICATION NAME] 1.5 - 1 can (250mls) BID (twice a day) which will provide 1,800kcal (kilocalories), 81 grams of protein, 933cc (cubic centimeter) free fluid, with 110cc H20 (water) Flush before and after each feeding bolus and continuous weekly weights one time a day . c. A Registered Dietician's (RD) Offsite Consultation dated 07/07/20 documented, . RD follow up due to TF (tube feeding) -3% weight change BMI (body mass index) -24.4 Reviewed weekly skin audit, labs available Estimated needs- 1,770kcal, 59 grams of protein, 1,770cc fluid TF order - [MEDICATION NAME] @ 50mls/hr (milliliters per hour) for 14 hours 6 p.m. to 8 a.m. Day time bolus feedings [MEDICATION NAME] 1.5 1 can (250mls) BID which will provide 1,800kcal, 81 grams of protein, 933cc free fluid, with 110cc H20 Flush before and after each feeding bolus and continuous RD recommends- continuing weekly weights . d. On 07/15/2020 at 11:15 A.M., LPN #1 administered a bolus tube feeding for Resident #25. She obtained a 250ml (milliliter) container of [MEDICATION NAME] 1.5cal (calorie) formula and 2 plastic drinking cups from the medication cart and water from the resident's bathroom sink. LPN #1was asked, How much water is in each cup? She replied, 90 cc's (cubic centimeters). She removed the plunger from the syringe and flushed with 90 ml water by gravity. She poured the formula into the syringe and allowed the formula to instill via bolus. She flushed with 90ml water by gravity. e. On 07/16/2020 at 3:16 P.M., LPN #1 was asked, I see an order to give 110ml H2O flushes before and after bolus. You gave 90 ml. Can you tell me why you gave 90? She replied, It was on the MAR (Medication Administration Record) to give 95 ml. That order was written on 6/12/20. But I guess it changed. She was asked, Is the current order for 90, or 95, or 110? She replied, It is 110 actually. f. A Policy titled Enteral Tube Feeding by Syringe (Bolus) provided by the Assistant Director of Nursing on 07/16/2020 at 1:59 P.M., documented, 1. Verify there is a Physician's Order for this Procedure . Equipment and Supplies . 7. Sixty (60) ml water (room temperature) . Initiate Feeding . 4. Unless otherwise ordered, follow the feeding with 30 - 60 ml of warm water . g. On 07/16/2020 at 3:32 P.M., the Administrator was asked, What could happen if a resident did not receive the ordered amount of free water flushes through their feeding tube? She replied, If it is not enough, they won't get the right amount of water and it could cause issues in lots of different areas like skin integrity, dehydration, and nutritional intake. Even though it's just water they still need it.
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 that the physician's orders were followed on oxygen administration for 1 (Resident #13) of 7 (Resident's #4, #6, #13, #27, #31, #36, and #45) sampled residents. This failed practice had the potential to affect 9 residents who were on oxygen therapy based on a list provided by the Administrator on 07/16/2020. The findings are: Resident #13 had a [DIAGNOSES REDACTED]. An Annual Minimum Data Set with an Assessment Reference Date of 04/22/2020 documented the resident scored 13 (13-15 indicated cognitively intact) per a Brief Interview of Mental Status and oxygen therapy while a resident. a. The July 2020 physician order documented, Oxygen @ (at) 2L (liters) VIA NC (nasal cannula) PRN (as needed) SOB (shortness of breath) every shift related to [MEDICAL CONDITION] With (Acute) Exacerbation . b. On 07/13/2020 at 11:41 A.M., the resident was receiving oxygen via nasal cannula. The gauge on the resident's oxygen concentrator was set on 3 liters. c. On 07/14/2020 at 10:00 A.M., t the resident was receiving oxygen via nasal cannula. The gauge on the resident's oxygen concentrator was set on 3 liters. d. On 07/16/2020 at 11:01 A.M., the resident was in bed and receiving oxygen at 3 liters via nasal cannula. e. On 07/16/2020 at 11:24 P.M., Licensed Practical Nurse #1 was asked, What the gauge on the resident's oxygen concentrator was set on? She replied, Looks like 3 (3 liters). The tube is dated 07/08/2020. She was asked, What does the resident's order state? She looked on the computer at the resident's Physician orders and stated, Right there it is saying 2 (2 liters). f. On 07/16/2020 at 4:09 P.M., the

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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F 0695 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 1) policy and procedure for oxygen administration provided by the Administrator documented, . Steps in the procedure . 8. Adjust the oxygen delivery device so that it is comfortable for the resident and the proper flow of oxygen is being administered . g. On 07/16/2020 at 4:41 P.M., the Administrator was asked, Who is responsible for checking the gauge to ensure the physician ordered amount of oxygen is being delivered and how often should it be checked? She replied, LPN's are to ensure the oxygen level setting is correct every shift.
F 0757 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Ensure each resident's drug regimen must be free from unnecessary drugs.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview the facility failed to ensure a risk versus benefits statement was provided by the physician for not ordering a dose reduction per recommendations by the pharmacist for 1 (Resident #50) of 16 (Residents #4, #6, #8, #9, #13, #14, #17, #27, #32, #34, #35, #36, #43, #44, #46, and #50) sampled residents who were on an antidepressant. This failed practice had the potential to affect 32 residents who were on an antidepressant based on a list provided by the Administrator on 07/17/2020. The findings are: Resident #50 had [DIAGNOSES REDACTED]. A Quarterly Minimum Data Set with an Assessment Reference Date of 07/02/2020 documented the resident scored 15 (13-15 indicated cognitively intact) per a Brief Interview of Mental Status and required supervision with bed mobility, locomotion in the unit, eating, toilet uses, and personal hygiene; required limited assistance with transfers, and dressing; and did not walk. Received an antidepressant medication 7 out of the last 7 days. a. A physician order [REDACTED]. [MEDICATION NAME] ([MEDICATION NAME]) Tablet 7.5 MG (milligrams) Give 1 tablet by mouth at bedtime related to Other Recurrent [MEDICAL CONDITION] . b. A Pharmacy Record Review dated 07/11/2019 documented, a recommendation for reduction or if continued requested a rationale for its continued use. The physician documented to continue the medication but gave no rationale for its continued use. c. The Pharmacy Record Review dated 07/07/2020 noted no discrepancies were found and did not a recommend a dose reduction for the reduction of [MEDICATION NAME]. c. On 07/15/2020 at 4:47 P.M., a review of the medical record documented the pharmacist had reviewed the resident's orders monthly. The [MEDICATION NAME] had not been addressed since 07/11/2019, at which time the pharmacist recommended reduction. The physician wrote to continue the current med regimen. No reasoning, no risks versus benefit was documented. [MEDICATION NAME] had not been addressed in 2020. d. On 07/16/2020 at 4:06 P.M., the Administrator was asked, When was the resident's last reduction attempt on [MEDICATION NAME] done? She looked in the resident's record and replied, On 07/11/2019 the monthly pharmacy checked (physician's orders [REDACTED]. The Doctor said continue current med (medication) regime with no changes. She was asked if there was a benefits versus risks documented. She replied No, there was a pharmacy review in 2020 but it did not address the [MEDICATION NAME]. e. On 07/16/2020 at 4:11 P.M., the Tapering Medications and Gradual Drug Dose Reduction policy documented, . a. During the first year in which a resident is admitted on a psycho pharma logical medication (other than antipsychotic or a sedative/hypnotic) or after the facility has initiated such medications, the facility will attempt to taper the medication during at least to separate quarters (with at least one month between the attempts), unless clinically contraindicated. The tapering may be indicated if: (1) The continued use is in accordance with relevant current standards of practice and the physician has documented the clinical rationale for why any attempted dose reduction would be likely to impair the resident's function or cause psychiatric instability .
F 0761 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Complaint (AR 126) was substantiated, all or in part, with deficiency cited at F761 Based on observation, record review and interview the facility failed to ensure discontinued non-narcotic medications were accounted for and secure from the date of discontinuation until the consultant pharmacist destroyed the medications for 2 (Resident #4, and #5) sampled residents. The findings are: 1. Resident #4 was admitted on [DATE] and expired in the facility under Hospice care on [DATE]. a. Resident #4's medical record had no documentation of a physician's orders [REDACTED]. b. A progress note written by Licensed Practical Nurse (LPN #1) on [DATE] documented, (Hospice RN (Registered Nurse) #1) (Hospice) here new orders received and noted [MEDICATION NAME] 2.5mg (milligrams) times one now [MEDICATION NAME] 1mg (milligram) SL (sublingual) every 6 hours as needed for anxiety agitation or restlessness . c. Photos #16, #17, and #18 provided by the complainant documented, a medication bottle with a pharmacy label with Resident #4's name, the nursing facility name, [MEDICATION NAME] concentrate 2mg/ml (milligrams per milliliter), dispense date [DATE] filled by (Pharmacy) and Rx (prescription) number. The background of the photo reveals bubble pack cards of unknown medication. Unable to determine where the photos were taken. d. On [DATE] at 11:00 a.m., LPN#1 was asked, Do you remember when you wrote a progress note back in March for Resident #4 saying (Hospice RN #1) gave you an order for [REDACTED]. She was asked, Can you look on the electronic record and find where that order was put in the record and on the MAR? She replied, Let me look and I will get back with you. e. On [DATE] at 12:30 p.m., LPN #1 stated, I don't think I ever wrote the order for that [MEDICATION NAME] or put it in the computer. I told (Hospice RN #1) that we could get the injectable [MEDICATION NAME] from the E (emergency)-kit and give an IM (intramuscular) injection but that we didn't have any sublingual. I don't think I ever wrote the order or made a progress note saying we changed it. To my knowledge the sublingual medicine was never ordered and never came from the pharmacy. She was asked, What is the protocol for the destruction of discontinued non-narcotic medications? She replied, There is a tub in the med room and a blue book to log the medicine in. Sometimes we log them in and sometimes the DON does it. Then the pharmacy comes to waste it. She was asked, Who has access to the discontinued medication cabinet? She replied, Just the med (medication) nurses, the DON, and ADON (Assistant Director of Nursing). She was asked, Is it possible for a nurse to remove discontinued medicine from the discontinued medication cabinet between the date that a med is discontinued and the date the pharmacist comes? She replied, Sure. I guess anything is possible. f. On [DATE] at 4:00 p.m., Hospice RN #1 was asked, How does the facility receive medications for residents who receive hospice care? She replied, If it's during normal working hours, we use (Pharmacy) in (City) and one of our staff members delivers it to the facility. If it's after normal working hours, we use (Pharmacy), but we have their courier deliver it to the facility. If it's a STAT (immediate) order, we use the backup pharmacy - the local pharmacy in (City) because that is the one the DON wants us to use, and they deliver it. She was asked, Are you familiar with Resident #4? She replied, Yes. She was asked, Do you recall on [DATE] you talked to LPN #1 about giving [MEDICATION NAME] sublingual? She replied, Yes. LPN #1 told me that they did not have the sublingual in their E-kit, but they had the injectable. So, we immediately changed it to the injectable. She was asked, Was the sublingual medication ever ordered from the pharmacy? She replied, Not to my knowledge because we changed it right then. I know I did not call it in. She was asked, What happens to a resident's medication when they expire, and they are in hospice care? She replied, The facility is responsible for the medication. They are responsible for the count if it's a narcotic. They are responsible for everything including the destruction of the medication. g. On [DATE] at 8:25 a.m., Pharmacist #1 was asked, Who called in the prescription for Resident #4 to the pharmacy and who received the medication? She replied, (Hospice RN #1) called it in. It was picked up by the (Hospice RN #2). h. On [DATE] at 11:00 a.m., Hospice RN #2 was asked, Do you remember Resident #4? She replied, Yes. She was asked, Do you remember picking up [MEDICATION NAME] suspension from the pharmacy and delivering it to (Facility)? She replied, Yes. She was asked, Do you remember who you gave it to? She replied, Let me check my notes I'm sure I wrote it down. She stated, If I remember correctly, we never had to administer it because she was comfortable, and we ended her continuous care. She stated, I gave it to LPN #1 at the facility. She was asked, When a resident dies, does the hospice nurse take the resident's meds from the facility? She replied, No. The facility disposes of the meds according to their protocol. i. On [DATE] at 9:40 a.m., LPN #4 was asked, What is the protocol for destruction of discontinued non-narcotic medications? She replied, There is a DC (discontinued) bin under the sink in the med room. The DON and the pharmacist count the meds and log it in a blue book and destroy the meds in a sharps container. She was asked, Who has access to the bin under the sink in the med room? She replied, Pretty much anyone who has access to the med room. She was asked, Could it be possible for someone to remove meds from the bin before the pharmacist comes? She answered, Yes. She was asked, Do you remember Resident #4 had an order for [REDACTED]. She was asked, Have you ever taken a resident's discontinued medication from the facility? She replied, No ma'am. j. On [DATE] at 11:30 a.m., the DON opened an unlocked cabinet under the sink in the medication room. The discontinued non-narcotic medications were in a grey plastic bin with medication cards and other routes of medications. She stated, We do the narcs (narcotics) a different

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F 0761 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 2) way. I keep them in my office and send them to the state. She was asked, What is the procedure for destroying discontinued non-narcotic medications? She replied, The nurses put them under here in this bin. When the pharmacist comes, we log them in the blue book and destroy them together and they sign off. She was asked, Is that the only time medications are logged in the book? She replied, Well, if the bin gets too full, I go ahead and log them in and they sign off after me. She was asked, How often does a pharmacist come? She replied, Once a month. Last time they were here was [DATE]rd. The Blue Medication Destruction Book had stickers from the pharmacy applied to the pages and a number hand-written on each sticker. The DON was asked, What is that number? She replied, That's how many pills there were. She was asked, Who has access to the discontinued medication cabinet? She replied, The med nurses, me, the ADON and the Administrator. She was asked, Could a nurse remove medication from the discontinued medication cabinet between the date a med is discontinued and the date the pharmacist comes? She replied, I guess anything could happen. She was asked, Can you find where Resident #4's [MEDICATION NAME] Conc (Concentrate) 2mg/ml was logged in and destroyed? She looked at several pages and answered, I don't see where it was ever logged in. Let's look in my office and see if they were sent back with the narcotics. She checked the binder in her office. There was no record the [MEDICATION NAME] Conc was surrendered to the state after the death of Resident #4. She stated, I wasn't sure if that was a narcotic or not. One day it is, one day it's not. k. A Discharge Summary dated [DATE] documented . All meds were given to the DON (Director of Nursing) for destruction . 2. Resident #5 was admitted to the facility on [DATE]. a. A physician's orders [REDACTED]. [MEDICATION NAME] 200mg Give one capsule three times a day for cough . The [DATE] Medication Administration Record [REDACTED]. b. A physician's orders [REDACTED]. [MEDICATION NAME] Capsule 100 MG ([MEDICATION NAME]) Give 100 mg by mouth every 8 hours as needed for cough for 14 Days . The [DATE] MAR indicated [REDACTED]. c. As of [DATE], there was not an active physician's orders [REDACTED].#5'smedical records. d. Photos #9, #10, and #11 provided by the complainant documented bubble packed cards of [MEDICATION NAME] 100mg capsules with 2 capsules in each blister, with Resident #5's name, (Pharmacy), Rx number and dispense date [DATE]. Photo #9's background shows a bathroom sink and countertop with makeup and personal care items and possible nasal spray. e. On [DATE], no sink resembling the sink in photo #9 was in the facility. (Photos of facility sinks taken.) f. On [DATE] at 2:00 p.m., the DON was asked to contact the pharmacy and find out who ordered the cards of [MEDICATION NAME] 100mg caps for Resident #5 on [DATE]. She called (Pharmacy) and was told the medication was reordered on [DATE] by (LPN #3). The ADON provided 4 pages faxed from (Pharmacy) titled Consolidated Delivery Sheets for Resident #5. Page 1 dated [DATE] documented, [MEDICATION NAME] 200mg capsules 15 cap (capsules) 3 items sent. Page 2 dated [DATE] documented, [MEDICATION NAME] 100mg cap 30 caps. Page 3 dated [DATE] documented, [MEDICATION NAME] 200mg capsules 15 cap 3 items sent. Page 4 dated [DATE] documented, [MEDICATION NAME] 100mg capsules 100 capsules 2 items sent and received in the facility at 1615 (4:15 p.m.) on [DATE]. g. On [DATE] at 2:10 p.m., LPN #3 was asked, Do you remember reordering Resident #5's [MEDICATION NAME] 100mg caps on [DATE]? He replied, I don't remember it, but I do remember she had an order for [REDACTED]. h. On [DATE] at 2:30 p.m., the DON looked in the Blue Medication Destruction book. There was no documentation of [MEDICATION NAME] 100mg capsules for Resident #5 logged into the blue book for destruction. The DON stated Let me go look one more place in the med room. There's a place where we keep overflow meds. Maybe it's there. i. On [DATE] at 9:15 a.m., the DON was asked, Did you find the cards of [MEDICATION NAME] for Resident #5 that you were going to look for yesterday? She replied, No I never found it. j. On [DATE] at 9:40 a.m., LPN #4 was asked, Do you remember from December when Resident #5 had a prescription for [MEDICATION NAME] capsules? She replied, Not really. I am working the COVID unit today and my computer is too far away for me to look anything up. k. On [DATE] at 1:45 p.m., the DON was asked, Who is responsible for ensuring all medications are placed in the discontinued bin when a medication is discontinued or when a resident dies? She replied, The nurse who is working when the medication is discontinued or when the resident dies. She was asked, Is it ever acceptable for medications to be missing from the facility? She replied, No, that is never acceptable.