STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045450	A. BUILDING _____ B. WING _____	**03/13/2020**

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

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0583 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Keep residents' personal and medical records private and confidential.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the facility failed to ensure that dignity was provided for the resident during personal care for 5 non-samples residents. The failed practice had the potential to affect all 86 residents as documented on Resident Census and Condition of Residents form provided by the Administrator on [DATE]20. The findings are: 1. On 3/10/2020 at 8:45 am, the door was open to room [ROOM NUMBER]. The privacy curtain was pulled halfway while the Certified Nursing Assistants (CNAs) were providing resident care. 2. On 3/10/2020 at 9:19 am, the door was open to room [ROOM NUMBER]. The privacy curtain was pulled halfway while CNAs were providing resident care. 3. On 3/10/2020 at 9:32 am, the door was open to room [ROOM NUMBER]. The privacy curtain was pulled halfway while CNAs were providing resident care. 4. On 3/10/2020 at 10:02 am, the door was open to room [ROOM NUMBER]. The privacy curtain was not pulled while staff were assisting the resident with care. 5. On 3/10/2020 at 11:12 am, the door was open to room [ROOM NUMBER]. The privacy curtain was pulled halfway while the CNAs were providing resident care. 6. On 3/13/2020 at 9:35 am, Registered Nurse (RN) #1 was asked, Should the door be closed while the staff is providing care? and she stated, Yes. The door needs to be shut. She was asked, Has the staff be been educated or in-serviced to provide privacy during care or when assisting the resident with care? and she stated, Yes. 7. On 3/13/2020 at 9:37 am, Certified Nursing Assistant (CNA) #1 was asked, Should the door be closed while the staff is providing care? and she stated, Yes Ma'am. She was asked, Has the staff be been educated or in-serviced to provide privacy during care or when assisting the resident with care? and she stated, Yes Ma'am. 8. On 3/13/2020 at 9:45 am, Licensed Practical Nurse #1 was asked, Should the door be closed while the staff is providing care? and she stated, Yes. She was asked, Has the staff be been educated or in-serviced to provide privacy during care or when assisting the resident with care? and she stated, Yes. 9. On 3/13/2020 at 9:51 am, Licensed Practical Nurse (LPN) #2 was asked, Should the door be closed while the staff is providing care? and she stated, Yes. She was asked, Has the staff be been educated or in-serviced to provide privacy during care or when assisting the resident with care? and she stated, Yes Ma'am. 10. On 3/13/2020 at 9:55 am, Certified Nursing Assistant (CNA) #2 was asked, Should the door be closed while the staff is providing care? and she stated, Yes Ma'am. She was asked, Has the staff be been educated or in-serviced to provide privacy during care or when assisting the resident with care? and she stated, Yes Ma'am. 11. On 3/13/2020 at 10:10 am, the Director of Nursing (DON) was asked, Should the door be closed while the staff is providing care? and she stated Yes. She was asked, Has the staff be been educated and in-serviced to provide privacy during care or when assisting the resident with care? and she stated, Not since I've been here.
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** Based on observation and interviews the facility failed to ensure hazards material was secured in resident rooms on 3 (200, 300, and 400) halls. This failed practice had a potential to affect all 86 residents as documented on the Resident Census and Conditions of Residents form provided by the Administrator on [DATE]20. The findings are: 1. On 3/10/2020 at 9:14 am, there was cornstarch baby powder, [MED], and Brushless Shave Cream on the over the bed table in Resident room [ROOM NUMBER]-1. 2. On 3/10/2020 at 9:19 am, there was [MED], [MEDICATION NAME] toothpaste, powder, [MED], and body spray on the over bed table in Resident room [ROOM NUMBER]-2. 3. On 3/10/2020 at 9:26 am, there was peroxide and wound cleanser on the bedside table and in Resident room [ROOM NUMBER]-1. 4. On 3/10/2020 at 9:32 am, there was deodorizing room spray (aerosol and pump style) in the window seal on the resident's room in Resident room [ROOM NUMBER]-2. 5. On 3/10/2020 at 9:51 am, there was deodorizing room spray, mouth wash, hand sanitizer, Vaseline, barrier cream, and cold therapy pain relief on the over bed table in Resident room [ROOM NUMBER]-1. 6. On 3/10/2020 at 10:07 am, there was wound cleanser, skin protector, peroxide, medical adhesive, peroxide on the bed side table in Resident room [ROOM NUMBER]-1. 7. On 3/10/2020 at 10:17 am, there was full body wash and peri-cleanser and moisturizing lotion on the bedside table in Resident room [ROOM NUMBER]-1. 8. On 3/10/2020 at 10:21 am, there was room deodorizing room spray (aerosol) on the over bed table in Resident room [ROOM NUMBER]-1. 9. On 3/10/2020 at 10:22 am, there was body powder, eye drops, pain relieving ointment, mouthwash, and shaving cream in a chair next to the bed in Resident room [ROOM NUMBER]-2. 10. On 3/10/2020 at 10:33 am, there was Lysol on the bed side table in Resident room [ROOM NUMBER]-2. 11. On 3/13/2020 at 9:32 am, Registered Nurse (RN) #1 was asked, Do you have residents that self-administer mediations? and she stated, No. She was asked, Should a resident have Activities of Daily Living (ADL) supplies, wound care supplies, medications (OTC (over the counter) or prescribed) or room deodorizing spray on the bedside table or on the over the bed table? She stated, No. She was asked, What could happen if a cognitively impaired resident picks it up and ingest it? She stated, They could get sick. 12. On 3/13/2020 at 9:37 am, Certified Nursing Assistant (CNA) #1 was asked, Do you have residents that self-administer mediations? and she stated, I don't know. She was asked, Should a resident have ADL supplies, wound care supplies, medications (OTC or prescribed) or room deodorizing spray on the bedside table or on the over the bed table? She stated, No. She was asked, What could happen if a cognitively impaired resident picks it up and ingest it? She stated, Be hospitalized or be sick. 13. On 3/13/2020 at 9:45 am, Licensed Practical Nurse (LPN) #1 Do you have residents that self-administer mediations? and she stated, No. She was asked, Should a resident have ADL supplies, wound care supplies, medications (OTC or prescribed) or room deodorizing spray on the bedside table or on the over the bed table? She stated, No. She was asked, What could happen if a cognitively impaired resident picks it up and ingest it? She stated, Death, Aspiration, get sick. 14. On 3/13/2020 at 9:52 am, LPN #2 was asked, Do you have any residents self-administer mediations? and she stated, No. She was asked, Should a resident have ADL supplies, wound care supplies, medications (OTC or prescribed) or room deodorizing spray on the bedside table or on the over the bed table? She stated, No. She was asked, What could happen if a cognitively impaired resident picks it up and ingest it? She stated, They could lose their life. 15. On 3/13/2020 at 10:02 am, the Director of Nursing (DON) was asked, Do you have any residents self-administer mediations? and she stated, No. She was asked, Should a resident have ADL supplies, wound care supplies, medications (OTC or prescribed) or room deodorizing spray on the bedside table or on the over the bed table? She stated, Room sprays - No, ADL supplies should in the drawer, and medications - no. She was asked, What could happen if a cognitively impaired resident picks it up and ingest it? She stated, It could lead to poisoning.

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.