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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARKANSAS STATE VETERANS HOME AT NORTH LITTLE ROCK	2401 JOHN ASHLEY DRIVE NORTH LITTLE ROCK, AR 72114

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E 000	Initial Comments Note: The CMS-2567 (Statement of Deficiencies) is an official, legal document. All information must remain unchanged except for entering the plan of correction, correction dates, and the signature space. Any discrepancy in the original deficiency citation(s) will be reported to the Dallas Regional Office (RO) for referral to the Office of the Inspector General (OIG) for possible fraud. If information is inadvertently changed by the provider/supplier, the State Survey Agency (SA) should be notified immediately. The findings on this statement of deficiencies demonstrate non-compliance with §483.73 - Emergency Preparedness Requirements for Long-Term Care Facilities.	E 000		
E 039 SS=F	EP Testing Requirements CFR(s): 483.73(d)(2) (2) Testing. The [facility, except for LTC facilities, RNHCIs and OPOs] must conduct exercises to test the emergency plan at least annually. The [facility, except for RNHCIs and OPOs] must do all of the following: *[For LTC Facilities at §483.73(d):] (2) Testing. The LTC facility must conduct exercises to test the emergency plan at least annually, including unannounced staff drills using the emergency procedures. The LTC facility must do all of the following:] (i) Participate in a full-scale exercise that is community-based or when a community-based exercise is not accessible, an individual, facility-based. If the [facility] experiences an	E 039		

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

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E 039	Continued From page 1 actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in a community-based or individual, facility-based full-scale exercise for 1 year following the onset of the actual event. (ii) Conduct an additional exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, facility-based. (B) A tabletop exercise that includes a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed. *[For RNHCIs at §403.748 and OPOs at §486.360] (d)(2) Testing. The [RNHCI and OPO] must conduct exercises to test the emergency plan. The [RNHCI and OPO] must do the following: (i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group discussion led by a facilitator, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (ii) Analyze the [RNHCI's and OPO's] response to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCI's and OPO's] emergency plan, as needed.	E 039		

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E 039	Continued From page 2 This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure the integrated emergency response process was completed as required for the facility emergency preparedness program, as evidenced by failure to participate in a community or facility-based full or tabletop exercise to ensure the necessary preparation was made to provide for resident and staff safety in the event of an emergency for 1 of 1 facility. This failed practice had the potential to affect all 85 residents, as documented on the Clinical Resident List Report provided by the Administrator on 5/22/19. The findings are: On 5/22/19 at 2:45 p.m., the Maintenance Director was asked, has the facility participated in a community based or facility based full exercise or tabletop exercise as required? The Maintenance Director stated, "We did not. We were trying to work something out, but I left it in someone else's hands, and it hasn't been done." No documentation was provided for the integrated emergency response process.	E 039		
F 000	INITIAL COMMENTS The findings on this statement of deficiencies demonstrate non-compliance with 42 CFR part 483 requirements for Long Term Care facilities.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in	F 550		

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this section.

§483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident.

§483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source.

§483.10(b) Exercise of Rights.
The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States.

§483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility.

§483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart.
This REQUIREMENT is not met as evidenced by:
Based on observation, record review and interview, the facility failed to ensure residents at the same dining table were served meals at the

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same time to promote dignity and respect for 1 (Resident #5) of 4 (Resident #6, #7, #24, and #71) of sampled residents who ate in 1 Home of 8 "Homes". This failed practice had the potential to affect 20 residents who resided on Home 102 according to a list provided by the Director of Nursing (DON) on 5/22/19 at 1:55 p.m. The findings are:

Resident #5 had diagnoses of Parkinson's Disease, Anxiety Disorder, and Dysphagia. The Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 12/9/18, documented the resident scored 9 (8-12 indicates moderately impaired) on the Brief Interview for Mental Status (BIMS) and required limited assistance of one person for eating.

a. On 5/19/19 at 5:16 p.m., Resident #5 was sitting at the table with Resident #7. Resident #5 had nothing to eat in front of him. Resident #7 stated, "I received my plate 5 minutes ago."

At 5:19 p.m., Resident #24 arrived at the table and was served a meal. Resident #5 was still sitting at the table with nothing to eat. Resident #5 began reaching for the tray of condiments in the middle of the table.

At 5:23 p.m., Resident #7 had finished eating and left the table. Staff are laughing and conversing at the island in the middle of the kitchen. Resident #5 still had not been served his dinner tray.

At 5:33 p.m., Resident #24 had left the table after eating.

At 5:33 p.m., Resident #5 received a plate, 17 minutes after his table mates were served.

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F 550	Continued From page 5 Resident #5 was able to self-feed. Resident #5 was given a glass of water at this time. b. On 5/19/19 at 5:37 p.m., Universal Worker (UW) #5 was asked, "Can you tell me why Resident #5 was served last?" Universal Worker #5 replied, "No reason, we serve them as they come down." The Universal Worker was informed that Resident #5 had been sitting there since 5:16 p.m. The UW was asked, "Did you have to chop his food up?" Universal Worker #5 replied, "Yeah, I had to chop his food up, he's mechanical soft." Universal Worker #5 was asked, "Do you think Resident #5 having to sit and watch his table mates eat in front of him is a dignity issue?" Universal Worker #5 replied, "Yes." c. On 5/21/19 at 9:05 a.m., Licensed Practical Nurse (LPN) #1 was asked, "Would not serving all residents a meal at the same table, at the same time be considered a dignity issue?" LPN #1 replied, "Yeah, that's a problem."	F 550		
F 554 SS=E	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview the facility failed to ensure medications were not self-administered without a physician order and the interdisciplinary team (IDT) assessed the resident to determine safe administration for 1 (Resident #6) of 12 (Residents #6, #24, #43, 27, 19, 49, 71, 29, 45,	F 554		

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32, 76 and 128) sampled residents who received updraft treatments. This failed practice had the potential to affect 18 residents who had orders for updraft treatments as documented on a list provided by the Administrator on 6/7/19. The findings are:

Resident #6 had diagnoses of Chronic Obstructive Pulmonary Disease, Dyspnea, Systolic and Diastolic Congestive Heart Failure, and Hypertension. The Annual Minimum Data Set (MDS) with an Assessment Reference Date of 12/11/18, documented the resident scored 14 (13-15 indicates cognitively intact) on the Brief Interview for Mental Status (BIMS), required supervision with set up help only for bed mobility, transfer, had shortness of breath and received oxygen while a resident.

a. A Physician Order with a start date of 4/17/18 documented, "...Albuterol Sulfate Nebulization Solution (2.5 MG/3ML) [milligram/3 milliliter] 0.083% 2.5 mg inhale orally via nebulizer four times a day related to Chronic Obstructive Pulmonary Disease with (Acute) Exacerbation..."

b. On 5/19/19 at 4:43 p.m., Resident #6 was self-administering an updraft treatment in her room. There was no nurse in the room.

At 4:47 p.m., Resident #6 turned off the nebulizer and placed the tubing on the nebulizer. Resident #6 was asked, "Do you give yourself a breathing treatment all the time?" Resident # 6 stated, "Yes, they put it in for me and I give it to myself. I take it 4 times a day."

At 10:10 a.m., Resident #6 was pursed lipped breathing at this time. Resident #6 was asked,

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"Have you had your breathing treatment this morning?" Resident #6 stated, "No, I need one, I'm supposed to have it 4 times a day, the nebulizer helps me cough this stuff up and breathe, if they would just leave it for me, I'd do it myself."

At 10:25 a.m., Registered Nurse (RN) #1 entered the room and removed a clear vial with clear liquid from the locked cabinet, then she left the room. Resident #6 was coughing and continued the pursed lipped breathing.

At 10:27 a.m., RN #1 returned to the resident's room, and poured the vial with the clear liquid into the nebulizer and handed it to Resident #6.

c. On 5/21/19 at 9:05 AM, Licensed Practical Nurse (LPN) #1 was asked, "Are there any residents assessed to self-administer medications?" LPN #1 replied, "No."

At 9:07 a.m., LPN #2 was asked, "Are there any residents assessed to self-administer medications?" LPN #2 replied, "None that I'm aware of."

d. On 5/22/19 at 9:18 a.m., the Director of Nursing (DON) was asked, "Are there any residents in the facility that have an order to self-administer medications?" The DON replied, "We have one, a gentleman, [Resident #278]."

e. A document titled, "Self-Administration of Drugs" received from the DON on 5/16/19 at 3:55 p.m. documented, "...Residents in our facility who wish to self-administer their medications may do so, if it is determined that they are capable of doing so... As part of their overall evaluation, the

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F 554	Continued From page 8 staff and practitioner will assess each resident's mental and physical abilities, to determine whether a resident is capable of self-administering medications..."	F 554		
F 607 SS=E	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(3) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure their abuse prohibition policies and procedures were updated to reflect the current Federal regulations for 1 of 1 facility and failed to ensure the policy and procedures were implemented, as evidenced by failure of staff to immediately report an incident of possible resident-to-resident physical abuse to the Administrator, failure to ensure a thorough investigation was conducted and documented, and failure to report the incident to the Office of Long Term Care (OLTC) and other state agencies in accordance with state law for 1 (Resident #75) of 1 sampled resident who resided in Hero Home #6, was severely cognitively impaired and had a history of aggressive behaviors. This failed practice had the potential to affect 12 residents	F 607		

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who resided in Hero Home #6, as documented on Clinical Resident list provided by the Administrator on 5/22/19. The findings are:

1. The facility's Abuse, Neglect and Misappropriation policy and procedure, provided by the Administrator on 5/22/19 at 1:22 p.m., documented, "...Abuse, Neglect and Misappropriation of Resident Property...Policy: To ensure the resident is free of verbal, sexual, physical, and mental abuse, corporal punishment and involuntary seclusion... Procedure: 1. Any allegation of mistreatment of resident or property will be reported as required by regulations and law... 4. Prevention, Identification and Protection: The Administrator/Director of Nursing/RN on Duty must identify, intervene and correct situations in which abuse, neglect, and/or misappropriation may occur... The Administrator/Director of Nursing/RN [Registered Nurse] on Duty will monitor for sufficient staff, staff knowledge of resident needs, supervision of residents, and staff intervention of residents with needs and behaviors, which may lead to conflict or neglect...5. Reporting: Any employee who suspects an alleged violation must immediately notify the Administrator / Director of Nursing / RN on Duty. The supervisor on duty must notify the state agency and local law enforcement agency as required by law. The Administrator or designee will complete form 7734 and fax to 501-682-8551 or 501-682-8540 by 11:00 a.m. the following business day and mail the completed form 762 within 5 business days... The Administrator/Director of Nursing/RN on Duty must notify the resident's legal representative/responsible party regarding the alleged violation and assessment findings that an investigation has been initiated, and appropriate

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actions will be taken. This contact will be documented... 6. Investigation: The Administrator / Director of Nursing / Designee will conduct all investigations and record the interviews and results of the investigations. The investigation includes interviews of the alleged perpetrator, other employees or visitors, or any resident who might have knowledge of the alleged incident. A review of the resident's clinical record should occur to determine the resident's past history and condition for relevance to the alleged violation... 8. Documentation: The final report to the appropriate state agency must be completed as required by VA [Veterans' Affairs], state and federal regulations. This report should include the final determination of the investigation and corrective actions taken. Documentation in the resident's medical record should be made for continuity of care for the resident... Definitions: Abuse: the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. This includes the deprivation, by an individual including a caretaker, of goods or services that are necessary to attain or maintain physical, mental and psychosocial well-being..." The policy and procedure had not been updated to include the 2-hour reporting requirement that went into effect 11/28/17.

2. Resident #75 had diagnoses of Tremor, Degenerative Disease of Nervous System, Other Specified Depressive Episodes, Unspecified Dementia with Behavioral Disturbance, and Unspecified Mood [Affective] Disorder. The Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 1/10/19 documented the resident scored 3 (0-7 indicates severe impairment) on a Brief Interview for

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Mental Status (BIMS), had inattention and disorganized thinking behaviors daily, had wandering behaviors daily, and required supervision only for bed mobility, transfers, walking in room and corridor, and locomotion on and off the unit, was always continent of bowel and bladder, and received antipsychotic and antidepressant medication seven days of the last 7 days.

a. An Incident and Accident (I&A) dated 1/23/19 documented, "...Physical... Incident Location: Resident's Room... Nursing Description: Another resident stated that Veteran entered into his room and hit him across the face with a newspaper for no apparent reason... Immediate Action Taken Description: Monitoring Veteran to make sure she does not interact with the resident... No injuries observed at... People Notified... RN supervisor...Administrator...Nurse Practitioner...Director of Nursing...Family Member..."

b. An I&A dated 3/15/19 documented, "...Physical... Incident Location: Unknown...Nursing Description: Received report from DON, that resident went into another resident rooms and hit the resident on top of the head. DON directed the resident back to her room. Then took statement from the resident that was violated. I personally witnessed the resident displaying aggressive behavior, toward anyone that would approach her. [Advance Practice Registered Nurse] /family notified... Supervisor contacted, advised to monitor resident closely and notify family/DON... No injuries observed..." No further incidents of resident-to-resident aggression were documented in the clinical record or on the facility's Incident and Accident

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Log (provided by the Administrator on 5/22/19).

c. A Risk Management Note dated 3/15/19 documented, "...Another resident walked up to [Resident #69] and hit him on top of his head with a plastic coat hanger. [Resident #69] was emotionally upset and angry about the situation but received no injuries... Resident (with advanced dementia) who initiated the aggression was guided away from [Resident #69]'s presence and to her room. I stayed and spoke to [Resident #69] about the situation to calm him. Aggressive resident is being removed to hospital this evening..."

d. An In-Service dated 4/4/19 provided by the DON on 5/23/19 at 10:27 a.m. documented, "...anytime a resident is resistive towards care, combative make sure the resident is secure walk away let resident calm down then try approach later to continue with care...If resident continues to be resistive towards you get another staff member to assist resident...Always let charge nurse know about residents behavior so it can be documented accordingly..." This in-service was signed by employees, but did not specifically address resident-to-resident abuse or aggression.

e. On 05/22/19 at 02:43 PM, Resident #75 was up in a wheelchair with a placemat in her hand, folded and self-propelling her wheelchair around the kitchen. She then began to self-propel herself in the wheelchair around the home. She made three laps around the home in approximately twenty minutes.

f. On 05/22/19 at 10:50 AM, the Administrator was asked, but unable to provide a completed

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ARKANSAS STATE VETERANS HOME AT NORTH LITTLE ROCK	2401 JOHN ASHLEY DRIVE NORTH LITTLE ROCK, AR 72114

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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investigation report for the resident-to-resident incident on 1/24/19.

g. On 05/22/19 at 12:42 PM, the Administrator was asked, "What has been done to protect [Resident #69] from [Resident #75] from further abuse?" He stated, "They redirected her [Resident #75] and she went to Geripsych. [Geriatric Psychiatrist]". He was asked, "The incident in January was not investigated, correct?" He stated, "It was. There was a 7734 [initial reporting form] done." He was shown the report and was asked if he had any documentation of the investigation into that incident. He stated, "I'll have to look. They said they would be monitoring and supervise the residents and their interactions." He was asked, "Were these the same two residents involved in the incident in March?" He stated, "Yes ..."

h. On 05/22/19 at 1:44 PM, the Administrator was asked, "So was there a reportable [abuse reporting form] completed for the incident on 3/15/19?" He stated, "No, I did not do one."

i. On 05/22/19 at 2:44 PM, Resident #69 (who was assessed as cognitively intact per the MDS with an ARD of 3/5/19) was asked, "Did a resident come in here and hit you on the head?" He stated, "Yeah, she did hit me on the head." He was asked, "What did she hit you with?" He stated, "A coat hanger." He was asked, "Were you hurt?" He stated, "I had a little old bump on the top of my head. She knocked my glasses off and then she hit me on the top of the head with the coat hanger. I told the nurse that was here." He was asked, "Do you remember which nurse?" He stated, "No, but she don't work here anymore. That was a month ago or better." He was asked,

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F 607	Continued From page 14 "Does she come in your room?" He stated, "She comes in here all the time and bothers me." He was asked, "Does she come in here at night?" He stated, "Not that I know of, but she could. She's dangerous. I have told them. She follows me around and taps me on the shoulder all the time. I just try to stay away from here. They just turn her loose in here and she goes wherever she wants to ... j. On 05/23/19 at 11:18 AM, the Director of Nursing (DON) was asked, "Was there any abuse training or aggressive resident in-services after the incident between [Residents #75 and #69] in January and again in March?" She stated, "I will look one more time for this training." As of the survey exit date (5/23/19), no documentation of training on resident-to-resident aggression / abuse was provided.	F 607		
F 609 SS=E	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and	F 609		

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adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures.

§483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.
This REQUIREMENT is not met as evidenced by:
Based on record review and interview, the facility failed to ensure an incident of possible resident-to-resident physical abuse was immediately reported to the Office of Long Term Care (OLTC) and other state agencies in accordance with state law to enable the Administrator and agencies to provide oversight of the facility's investigation and protective measures for 1 (Resident #75) of 1 sampled resident who was severely cognitively impaired, resided in Hero Home #6, and had a history of aggressive behaviors toward other residents. This failed practice had the potential to affect 12 residents who resided in Hero Home #6, as documented on Clinical Resident list provided by the Administrator on 5/22/19. The findings are:

1. Resident #75 had diagnoses of Tremor, Degenerative Disease of Nervous System, Other Specified Depressive Episodes, Unspecified Dementia with Behavioral Disturbance, and Unspecified Mood [Affective] Disorder. The Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 1/10/19 documented the resident scored 3 (0-7 indicates

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severe impairment) on a Brief Interview for Mental Status (BIMS), had inattention and disorganized thinking behaviors daily, had wandering behaviors daily, and required supervision only for bed mobility, transfers, walking in room and corridor, and locomotion on and off the unit, was always continent of bowel and bladder, and received antipsychotic and antidepressant medication seven days of the last 7 days.

a. An Incident and Accident (I&A) dated 1/23/19 documented, "...Physical... Incident Location: Resident's Room... Nursing Description: Another resident stated that Veteran entered into his room and hit him across the face with a newspaper for no apparent reason... Immediate Action Taken Description: Monitoring Veteran to make sure she does not interact with the resident... No injuries observed at... People Notified... RN supervisor...Administrator...Nurse Practitioner...Director of Nursing...Family Member..."

b. An I&A dated 3/15/19 documented, "...Physical... Incident Location: Unknown...Nursing Description: Received report from DON, that resident went into another resident rooms and hit the resident on top of the head. DON directed the resident back to her room. Then took statement from the resident that was violated. I personally witnessed the resident displaying aggressive behavior, toward anyone that would approach her. [Advance Practice Registered Nurse]/family notified... Supervisor contacted, advised to monitor resident closely and notify family/DON... No injuries observed at...."

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F 609	Continued From page 17 c. A Risk Management Note dated 3/15/19 documented, "...Another resident [Resident #75] walked up to [Resident #69] and hit him on top of his head with a plastic coat hanger. [Resident #69] was emotionally upset and angry about the situation but received no injuries... Resident (with advanced dementia) who initiated the aggression was guided away from [Resident #69]'s presence and to her room. I stayed and spoke to [Resident #69] about the situation to calm him. Aggressive resident is being removed to hospital this evening..." There were no further incidents of resident-to-resident aggression / abuse involving Resident #75 documented in the clinical record or Incident / Accident Log (provided by the Administrator on 5/22/19). d. On 05/22/19 at 12:42 PM, the Administrator was asked, "What has been done to protect [Resident #69] from [Resident #75] from further abuse?" He stated, "They redirected her [Resident #75] and she went to Geripsych. [Geriatric Psychiatrist]". He was asked, "Were these the same two residents involved in the incident in March?" He stated, "Yes ..." e. On 05/22/19 at 1:44 PM, the Administrator was asked, "Was there a reportable [abuse reporting form] completed for the incident on 3/15/19?" He stated, "No, I did not do one."	F 609		
F 610 SS=E	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged	F 610		

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violations are thoroughly investigated.

§483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress.

§483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.
This REQUIREMENT is not met as evidenced by:
Based on record review and interview, the facility failed to ensure a thorough investigation was conducted and the results reported within 5 days to the Office of Long Term Care (OLTC) and other state agencies after a cognitively impaired resident exhibited aggressive behaviors / abuse toward another resident to enable those agencies to provide oversight of the facility's investigative / protective efforts for 1 (Resident #75) of 1 sampled resident who was severely cognitively impaired, resided in Hero Home #6 and had a history of aggressive behaviors toward other residents. This failed practice had the potential to affect 12 residents who resided in Hero Home #6, as documented on Clinical Resident list provided by the Administrator on 5/22/19. The findings are:

1. Resident #75 had diagnoses of Tremor, Degenerative Disease of Nervous System, Other Specified Depressive Episodes, Unspecified Dementia with Behavioral Disturbance, and Unspecified Mood [Affective] Disorder. The Quarterly Minimum Data Set (MDS) with an

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Assessment Reference Date (ARD) of 1/10/19 documented the resident scored 3 (0-7 indicates severe impairment) on a Brief Interview for Mental Status (BIMS), had inattention and disorganized thinking behaviors daily, had wandering behaviors daily, and required supervision only for bed mobility, transfers, walking in room and corridor, and locomotion on and off the unit, was always continent of bowel and bladder, and received antipsychotic and antidepressant medication seven days of the last 7 days.

a. An Incident and Accident (I&A) dated 1/23/19 documented, "...Physical... Incident Location: Resident's Room... Nursing Description: Another resident stated that Veteran entered into his room and hit him across the face with a newspaper for no apparent reason... Immediate Action Taken Description: Monitoring Veteran to make sure she does not interact with the resident... No injuries observed at... People Notified... RN supervisor...Administrator...Nurse Practitioner...Director of Nursing...Family Member..."

b. An I&A dated 3/15/19 documented, "...Physical... Incident Location: Unknown...Nursing Description: Received report from DON, that resident went into another resident rooms and hit the resident on top of the head. DON directed the resident back to her room. Then took statement from the resident that was violated. I personally witnessed the resident displaying aggressive behavior, toward anyone that would approach her. [Advances Practice Registered Nurse] /family notified... Supervisor contacted, advised to monitor resident closely and notify family/DON... No injuries observed..."

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No further incidents of resident-to-resident aggression were documented in the clinical record or on the facility's Incident and Accident Log (provided by the Administrator on 5/22/19).

c. A Risk Management Note dated 3/15/19 documented, "...Another resident walked up to [Resident #69] and hit him on top of his head with a plastic coat hanger. [Resident #69] was emotionally upset and angry about the situation but received no injuries... Resident (with advanced dementia) who initiated the aggression was guided away from [Resident #69]'s presence and to her room. I stayed and spoke to [Resident #69] about the situation to calm him. Aggressive resident is being removed to hospital this evening..."

d. On 05/22/19 at 02:43 PM, Resident #75 was up in a wheelchair with a placemat in her hand, folded and self-propelling her wheelchair around the kitchen. She then began to self-propel herself in the wheelchair around the home. She made three laps around the home in approximately twenty minutes.

e. On 05/22/19 at 10:50 AM, the Administrator was asked, but unable to provide a completed investigation report for the resident-to-resident incident on 1/24/19.

f. On 05/22/19 at 12:42 PM, the Administrator was asked, "The incident in January was not investigated, correct?" He stated, "It was. There was a 7734 [initial reporting form, which is not the 5-day completed investigation form] done." He was shown the report and was asked if he had any documentation of the investigation into that incident. He stated, "I'll have to look. They said

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F 610	Continued From page 21 they would be monitoring and supervise the residents and their interactions." He was asked, "Were these the same two residents involved in the incident in March?" He stated, "Yes ..." g. On 05/22/19 at 1:44 PM, the Administrator was asked, "So was there a reportable [abuse reporting form] completed for the incident on 3/15/19?" He stated, "No, I did not do one." h. On 05/22/19 at 2:44 PM, Resident #69 (who was assessed as cognitively intact per the MDS with an ARD of 3/5/19) was asked, "Did a resident come in here and hit you on the head?" He stated, "Yeah, she did hit me on the head." He was asked, "What did she hit you with?" He stated, "A coat hanger." He was asked, "Were you hurt?" He stated, "I had a little old bump on the top of my head. She knocked my glasses off and then she hit me on the top of the head with the coat hanger. I told the nurse that was here." He was asked, "Do you remember which nurse?" He stated, "No, but she don't work here anymore. That was a month ago or better." He was asked, "Does she come in your room?" He stated, "She comes in here all the time and bothers me." He was asked, "Does she come in here at night?" He stated, "Not that I know of, but she could. She's dangerous. I have told them. She follows me around and taps me on the shoulder all the time. I just try to stay away from here. They just turn her loose in here and she goes wherever she wants to ..."	F 610		
F 623 SS=E	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a	F 623		

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resident, the facility must-
(i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman.
(ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and
(iii) Include in the notice the items described in paragraph (c)(5) of this section.

§483.15(c)(4) Timing of the notice.
(i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged.
(ii) Notice must be made as soon as practicable before transfer or discharge when-
(A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section;
(B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;
(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;
(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or
(E) A resident has not resided in the facility for 30 days.

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F 623	Continued From page 23 §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon	F 623		

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as practicable once the updated information becomes available.

§483.15(c)(8) Notice in advance of facility closure
In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l).
This REQUIREMENT is not met as evidenced by:
Based on record review and interview, the facility failed to ensure written notification of transfer/discharge to the hospital was provided to the resident and/or the resident's representative to protect resident rights for 1 (Residents #24) of 22 (Residents # 2, 3, 5, 19, 20, 22, 23, 24, 26, 27, 28, 30, 32, 38, 43, 45, 48, 54, 65, 69, 75, and #78) sampled residents who were sent to the hospital from January 2019 to April 2019. This failed practice had the potential to affect 36 residents who were sent to the hospital from January 2019 to April 2019 as documented on a list provided by the Business Office Manager (BOM) on 5/23/19 at 9:50 a.m. The findings are:

Resident #24 had diagnoses of Chronic Obstructive Pulmonary Disease, Respiratory Disorder, Hypertension, History of Transient Ischemic Attack, Acute Bronchitis, and Atrial Flutter. The Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 12/28/18 documented the resident scored 15 (13-15 cognitively intact) on the Brief Interview for Mental Status.

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ARKANSAS STATE VETERANS HOME AT NORTH LITTLE ROCK	2401 JOHN ASHLEY DRIVE NORTH LITTLE ROCK, AR 72114

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 623	Continued From page 25 a. The Progress notes dated 3/19/19 documented Resident #24 had a fall. Resident #24 sustained injury and was sent to the hospital for evaluation. b. On 05/22/19 at 10:02 a.m., the Director of Nursing (DON) was asked for the transfer and bed hold policy that was provided to the resident and the resident's family on 3/19/19. The DON replied, "We cannot find one."	F 623		
F 625 SS=E	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the	F 625		

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resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by:

Based on record review and interview the facility failed to ensure a resident/representative were provided with a copy of the facility's bed-hold policy when the resident was transferred to the hospital and / or discharged to ensure the resident/representative was informed of the policy and any potential bed hold charges for 9 (Residents #2, 54, 75 and 24, 20, 26, 28, 30 and 45) of 22 (Resident #2, 3, 5, 19, 20, 22, 23, 24, 26, 27, 28, 30, 32, 38, 43, 45, 48, 54, 65, 69, 75, and #78) sampled residents who were sent to the hospital from January 2019 to April 2019. This failed practice had the potential to affect 36 residents who were sent to the hospital from January 2019 to April 2019 as documented on a list provided by the Business Office Manager (BOM) on 5/23/19 at 9:50 a.m. The findings are:

1. Resident #2 had diagnoses of Essential (Primary) Hypertension, and Chronic Obstructive Pulmonary Disease. The Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 12/6/18 documented the resident scored 6 (0-7 indicates severe impairment) on a Brief Interview for Mental Status (BIMS).

A transfer notice letter dated 4/22/19 documented the resident went to the [Outside Hospital #1] on 4/21/19.

On 5/23/19 at 9:50 a.m., The Business Office Manager stated, "We did not send a bed hold policy."

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F 625	Continued From page 27	F 625		

2. Resident #54 had diagnoses of Dementia with Behavioral Disturbance, Paranoid Schizophrenia, and Other Recurrent Depressive Disorders. The Admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 11/15/18 documented, was moderately impaired in cognitive skills for daily decision making per a staff assessment for mental status, (SAMS).

a. A Health Status Note dated 1/16/19 documented, "...Resident reporting pain all over when LPN entered dining area, LPN attempting to get vital signs and neurological check at around 07:00. Resident reports severe pain when LPN attempted to move right elbow. Resident refused vital signs at that time. Resident alert and oriented to self. Hand grasp equal, resident refused to open eyes at this time. Contacted RN Supervisor and informed of situation instructed to contact APRN. APRN ordered send to hospital via ambulance now. Informed RN Supervisor, DON, and family of order. Contacted [Ambulance Service #1] and informed of situation. UWs [Universal Workers] able to get vital signs at around 07:20. Vital signs within normal limits. Resident left via ambulance at 07:30.

b. A Health Status Note dated 1/16/19 documented, "....Resident returned via ambulance at around 09:50. There was no documentation in the transfer letter to indicate the resident or resident representative was notified of the bed hold policy.

3. Resident #75 had diagnosis of Tremor, and Degenerative Disease of Nervous System. The Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 1/10/19 documented the resident scored 3 (0-7 indicates

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severe impairment) on a Brief Interview for Mental Status (BIMS).

The March 2019 Emergency transfer list documented the resident transferred to the hospital on 3/16/19. There was no documentation to indicate a bed-hold notice was provided to the resident or the resident representative.

4. The January 2019 Emergency transfer list documented Resident #20 was transferred to [Outside Hospital #3] on 1/15/19. There was no documentation to indicate the resident/representative was notified of a bed-hold policy.

5. The January 2019 Emergency transfer list documented Resident #26 was transferred to Outside Hospital #3 on 1/10/19. There was no documentation to indicate the resident/representative was notified of a bed-hold policy.

6. The Progress Notes dated 3/3/19 documented Resident #28 was transferred to Outside Hospital #3. There was no documentation to indicate the resident/representative was notified of a bed-hold policy.

7. The January 2019 Emergency transfer list documented Resident #30 was transferred to Outside Hospital #3 on 12/19/18. There was no documentation to indicate the resident/representative was notified of a bed-hold policy.

8. The January 2019 Emergency transfer list documented Resident #45 was transferred to Outside Hospital #4 on 12/31/18 to 1/6/19. There

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was no documentation to indicate the resident/representative was notified of a bed-hold policy.

9. Resident #24 had a diagnoses of Chronic Obstructive Pulmonary Disease, Respiratory Disorder, Hypertension, History of Transient Ischemic Attack, Acute Bronchitis, and Atrial Flutter. The Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 12/28/18, documented the resident scored 15 (13-15 cognitively intact) on the Brief Interview for Mental Status.

a. The Progress notes dated 3/19/19 documented Resident #24 had a fall. Resident #24 sustained injury and was sent to the hospital for evaluation.

b. On 5/22/19 at 10:02 a.m., the Director of Nursing (DON) was asked for the transfer and bed hold policy that was provided to the resident and the resident's family on 3/19/19. The DON replied, "We cannot find one."

10. On 5/23/19 at 9:43 a.m., the Business Office Manager (BOM) was asked, "Will you provide documentation of the notification to the resident and/or the resident's representative of the facility policy for bed hold?" She stated, "I pulled the bed hold policies we had from the Admission packet. The previous [Administrative Analyst #1] was doing that. I noticed when you were asking for the transfers letters that the bed hold wasn't on there. So yesterday, I took our bed hold policy and combined it with the transfer letter so that each resident would be notified. I did put a plan in place to fix it and emailed it to the Social Services Director who is taking over and cc'd [Carbon Copied] the DON [Director of Nursing]

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F 625	Continued From page 30 and [Administrator] to let them know I fixed it."	F 625		
F 636 SS=E	Comprehensive Assessments & Timing CFR(s): 483.20(b)(1)(2)(i)(iii) §483.20 Resident Assessment The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. §483.20(b) Comprehensive Assessments §483.20(b)(1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following: (i) Identification and demographic information (ii) Customary routine. (iii) Cognitive patterns. (iv) Communication. (v) Vision. (vi) Mood and behavior patterns. (vii) Psychological well-being. (viii) Physical functioning and structural problems. (ix) Continence. (x) Disease diagnosis and health conditions. (xi) Dental and nutritional status. (xii) Skin Conditions. (xiii) Activity pursuit. (xiv) Medications. (xv) Special treatments and procedures. (xvi) Discharge planning. (xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS).	F 636		

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(xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts.

§483.20(b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs.
(i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or therapeutic leave.)
(iii)Not less than once every 12 months.
This REQUIREMENT is not met as evidenced by:
Based on record review and interview the facility failed to ensure Comprehensive Minimum Data Set (MDS) assessments were completed and transmitted within the regulatory time frames, to facilitate appropriate care planning and maintain current and accurate assessment records for 20 (Residents #21, #135, #3, 4, 23, 19, 13, 12, 16, 10, 27, 8, 22, 6, 7, 24, 25, 29, 31 and 43) of 20 sampled residents whose MDS were reviewed. This failed practice had the potential to affect 85 residents who resided in the facility as documented on the Resident's Census and Condition of Resident form dated 5/20/19. The findings are:

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1. Resident #21's annual MDS with an Assessment Reference Date (ARD) of 3/22/19 documented, "Still in progress" as of 5/23/19, 47 days after the ARD.

2. Resident #135's admit MDS with an ARD of 4/27/19 documented, "Still in progress" as of 5/23/19, 24 days after the ARD.

3. Resident #4's Quarterly MDS with an ARD of 3/7/19 documented, "Still in progress" as of 5/23/19, 61 days after the ARD.

4. Resident #23's Quarterly MDS with an ARD of 3/27/19 documented, "Still in progress" as of 5/23/19, 41 days after the ARD.

5. Resident #19's Quarterly MDS with an ARD of 3/21/19 documented, "Still in progress" as of 5/23/29, 47 days after the ARD.

6. Resident #13's Quarterly MDS with an ARD of 3/19/19 documented, "Still in progress" as of 5/23/19, 49 days after the ARD.

7. Resident #12's Quarterly MDS with an ARD of 3/19/19 documented, "Still in progress" as of 5/23/19, 49 days after the ARD.

8. Resident #16's Quarterly MDS with an ARD of 3/26/19 documented, "Still in progress" as of 5/23/19, 42 days after the ARD.

9. Resident #10's Quarterly MDS with an ARD of 3/17/19 documented, "Still in progress" as of 5/23/19, 51 days after the ARD.

10. Resident #27's Quarterly MDS with an ARD of

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4/1/19 documented, "Still in progress" as of 5/23/19, 36 days after the ARD.

11. Resident #8's Quarterly MDS with an ARD of 3/13/19 documented, "Still in progress" as of 5/23/19, 55 days after the ARD.

12. Resident #22's Quarterly MDS with an ARD of 3/26/19 documented, "Still in progress" as of 5/23/19, 42 days after the ARD.

13. Resident #3 had an Annual Minimum Data Set (MDS) with an Assessment Reference Date of 3/14/19 which was not completed and transmitted as of 5/21/19.

14. Resident #6 had a Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 3/13/19, which was not completed and transmitted as of 5/21/19.

15. Resident #7's medical record contained a Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 3/15/19, which was not completed and transmitted as of 5/21/19.

15. Resident #24's record contained a Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 3/30/19, which was not completed and transmitted as of 5/22/19.

17. Resident #25's record documented a Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 3/31/19, which was not completed and transmitted as of 5/22/19.

18. Resident #29's record documented a

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F 636	Continued From page 34 Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 3/21/19, which was not completed and transmitted as of 5/22/19. 19. Resident #31's record documented a Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 4/9/19, which was not completed and transmitted as of 5/22/19. 20. Resident #43's record documented there was a Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 5/4/19, which was not completed and transmitted as of 5/22/19. 21. On 5/23/19 at 11:11 AM, Registered Nurse (RN) #3 was asked, "Should the resident's assessments be conducted on Admission, Quarterly, Annually and when a significant change has occurred and when a resident is admitted or discharged from Hospice?" RN #3 replied, "Yes." RN #3 was asked, RN #3 was asked, "How often are the resident assessments supposed to be completed and transmitted?" RN #3 replied, "92 days, they should be transmitted 14 days after completion." RN #3 was asked, "Can you tell me why the resident assessments have not been completed?" RN #3 replied, "I have only been here, maybe 30 days."	F 636		
F 637 SS=E	Comprehensive Assessment After Signifcant Chg CFR(s): 483.20(b)(2)(ii) §483.20(b)(2)(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For	F 637		

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purpose of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.)
This REQUIREMENT is not met as evidenced by:
Based on record review and interview the facility failed to ensure a significant change Minimum Data Set (MDS) was completed for 3 (Residents #2, #26, and #43) of 19 (Residents #2, 26, 43, 45, 9, 39, 71, 37, 67, 49, 41, 20, 18, 5, 16, 27, 32, 48, and 75) sampled residents who had a significant change in condition in the past 6 months. This failed practice had the potential to affect 23 residents who had a significant change in condition in the past 6 months according to a list provided by the Administrator on 6/7/19. The findings are:

1. Resident #26 had diagnoses of Seizure Disorder and Hemiplegia. The Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 10/6/18 documented the resident scored 5 (0-6 indicates severe impairment) on a Brief Interview for Mental Status (BIMS) and had inattention continuously, required extensive assistance from one staff member for bathing and was frequently incontinent of bladder and always incontinent of bowel.

The Quarterly MDS with an ARD of 1/5/19 documented the resident was severely impaired in cognitive skills for daily decision making per a Staff Assessment for Mental Status (SAMS), had

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continuous inattention and disorganized thinking, had verbal behaviors directed towards other and daily wandering, was totally dependent with physical assistance from one staff member for bathing and was always incontinent of bowel and bladder, and had a loss of 5% or more in the last month or loss of 10% or more in last 6 months. There was no Significant Change MDS completed.

2. Resident #2 had diagnoses of Chronic Obstructive Pulmonary Disease and Cardiac Arrhythmia. A Significant Change MDS with an ARD of 3/6/19 documented, "In Progress."

a. The Quarterly MDS with an ARD of 9/6/18 documented the resident scored 6 (0-7 indicates severe impairment) on a BIMS, required extensive physical assistance from two staff members for bed mobility, transfers, dressing, toileting and bathing, required extensive assistance from one staff member for personal hygiene, required supervision with of one staff member for locomotion on the unit and eating, was frequently incontinent of bowel and bladder, had two falls with no injury, had weight loss of 5% or more in the last month or loss of 10% or more in the last six months, and had other alarms.

b. The Quarterly MDS with an ARD of 12/6/18 documented the resident scored 6 (0-6 indicates severe impairment) on a BIMS, required extensive physical assistance from two staff members for bed mobility, transfers, dressing and bathing, required extensive assistance from one staff member for personal hygiene, required limited assistance from two staff members for locomotion off the unit, required limited physical assistance from one staff member for eating and

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F 637	Continued From page 37 toileting, was frequently incontinent of bowel and bladder, had 1 fall with no injury and had other alarm. There was a significant change in locomotion and toileting assistance. 3. Resident #43 had a diagnoses of Chronic Obstructive Pulmonary Disease, Hypertension, Systolic Congestive Heart Failure, Atrial Fibrillation, Diabetes Mellitus, and Cognitive Communication Deficit. The Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 2/1/19 documented the resident had modified independence on the Staff Assessment for Mental Status (SAMS), required extensive physical assistance of two persons for bed mobility, transfer, toilet use, required extensive physical assistance of one person for dressing, and required limited physical assistance of one person for personal hygiene, and was frequently incontinent of bowel and bladder. Resident #43 was admitted to Hospice on 3/19/19. There was no Significant Change Minimum Data Set (MDS) completed to indicate the significant change in condition.	F 637		
F 638 SS=E	Qrtly Assessment at Least Every 3 Months CFR(s): 483.20(c) §483.20(c) Quarterly Review Assessment A facility must assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months. This REQUIREMENT is not met as evidenced by: Based on record review and interview the facility failed to ensure a Minimum Data Set Quarterly assessment was completed at least every 3	F 638		

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months to identify and address any potential changes in care needs, for 6 (Residents #9, 11, 18, 26, 39, and 75) of 27 (Residents #26, 2, 9, 11, 18, 39, 48, 3, 6, 7, 24, 75, 29, 31, 21, 135, 4, 23, 19, 13, 12, 16, 10, 27, 8, 22, and 43) whose MDS were reviewed. This failed practice had the potential to affect 85 residents who required MD S assessments (total census: 85) as documented on the Resident Census and Conditions of Residents form dated 5/20/19. The findings are:

1. As of 5/21/19, Resident #9 had a Quarterly MDS with an assessment reference date (ARD) of 12/14/18. The resident's electronic health record documented a Quarterly MDS with an ARD of 3/14/19 was listed as "In progress."

2. As of 5/22/19, Resident #11 had an Admission MDS with an ARD of 9/18/18 accepted, a Quarterly MDS with an ARD of 12/18/18 accepted, and a Quarterly MDS with an ARD of 3/18/19 documented, "In progress."

3. As of 5/23/19, Resident #18 had a Significant Change MDS with an ARD of 9/21/18, a Quarterly MDS with an ARD of 12/21/18 and a Quarterly MDS with an ARD 3/21/19 was listed as "In Progress".

4. As of 5/21/19, Resident #26 had a Quarterly MDS with an ARD of 1/5/19 and a Quarterly MDS with an ARD of 4/5/19 was listed as "In progress."

5. Resident #39's Quarterly MDS with an ARD of 4/24/19 was documented as "In Progress".

6. Resident #75's had diagnoses of Other Specified Depressive Episodes, and Unspecified Dementia with Behavioral Disturbance. The last

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F 638	Continued From page 39 MDS Assessment conducted was a Quarterly MDS with an ARD of 1/10/19. A Quarterly MDS with an ARD of 4/12/19 should have been completed by 4/26/19. As of 5/22/19 a quarterly MDS was not in progress.	F 638		
F 640 SS=E	Encoding/Transmitting Resident Assessments CFR(s): 483.20(f)(1)-(4) §483.20(f) Automated data processing requirement- §483.20(f)(1) Encoding data. Within 7 days after a facility completes a resident's assessment, a facility must encode the following information for each resident in the facility: (i) Admission assessment. (ii) Annual assessment updates. (iii) Significant change in status assessments. (iv) Quarterly review assessments. (v) A subset of items upon a resident's transfer, reentry, discharge, and death. (vi) Background (face-sheet) information, if there is no admission assessment. §483.20(f)(2) Transmitting data. Within 7 days after a facility completes a resident's assessment, a facility must be capable of transmitting to the CMS System information for each resident contained in the MDS in a format that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by CMS and the State. §483.20(f)(3) Transmittal requirements. Within 14 days after a facility completes a resident's assessment, a facility must electronically transmit encoded, accurate, and complete MDS data to the CMS System, including the following:	F 640		

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F 640	Continued From page 40 (i)Admission assessment. (ii) Annual assessment. (iii) Significant change in status assessment. (iv) Significant correction of prior full assessment. (v) Significant correction of prior quarterly assessment. (vi) Quarterly review. (vii) A subset of items upon a resident's transfer, reentry, discharge, and death. (viii) Background (face-sheet) information, for an initial transmission of MDS data on resident that does not have an admission assessment. §483.20(f)(4) Data format. The facility must transmit data in the format specified by CMS or, for a State which has an alternate RAI approved by CMS, in the format specified by the State and approved by CMS. This REQUIREMENT is not met as evidenced by: Based on record review and interview the facility failed to ensure Minimum Data Set (MDS) assessments were submitted to the Centers for Medicare and Medicaid Services (CMS) within 14 days after completion to ensure current, accurate quality measures data for 27 (Residents #26, 2, 9, 11, 18, 39, 48, 3, 6, 7, 24, 25, 29, 31, 21, 135, 4, 23, 19, 13, 12, 16, 10, 27, 8, 22, and 43) of 27 sampled residents who MDS assessments were reviewed) This failed practice had the potential to affect 85 residents who required MDS assessments (total census: 85), as documented on the Resident Census and Conditions of Residents form dated 5/20/19 at 11:15 a.m. The findings are: 1. Resident #26 had a Quarterly MDS with an assessment reference date (ARD) of 4/5/19 which, as of 5/21/19 documented "In Progress."	F 640		

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2. Resident #2 had a Significant Change MDS with an ARD of 3/6/19 which, as of 5/21/19, documented "In Progress."

3. Resident #9 had a physician's order to admit to Arkansas Hospice on 8/31/18. As of 5/21/19 at 1:00 p.m., a Quarterly MDS with an ARD of 3/14/19 was listed as, "In progress."

4. Resident #11 had a Quarterly MDS with an ARD of 3/18/19 which, as of 5/22/19 documented, "In progress."

5. Resident #18 had a Quarterly MDS with an ARD of 12/21/18 and a Quarterly MDS with an ARD 3/21/19 which, as of 5/23/19 was listed as "In Progress."

6. Resident #39 had a Quarterly MDS with an ARD of 4/24/19 which, as of 05/20/19 at 01:38 PM documented "In Progress."

7. Resident #48 had diagnosis of Parkinson's Disease. As of 5/22/19 a Quarterly MDS with an ARD of 5/9/19 was listed as "In progress".

8. Resident #3 had an Annual Minimum Data Set (MDS) with an Assessment Reference Date of 3/14/19 which was not completed and transmitted as of 5/21/19.

9. Resident #6 had a Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 3/13/19, which was not completed and transmitted as of 5/21/19.

10. Resident #7's medical record contained a Quarterly Minimum Data Set (MDS) with an

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Assessment Reference Date (ARD) of 3/15/19, which was not completed and transmitted as of 5/21/19.

11. Resident #24's record contained a Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 3/30/19, which was not completed and transmitted as of 5/22/19.

12. Resident #25's record documented a Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 3/31/19, which was not completed and transmitted as of 5/22/19.

13. Resident #29's record documented a Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 3/21/19, which was not completed and transmitted as of 5/22/19.

14. Resident #31's record documented a Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 4/9/19, which was not completed and transmitted as of 5/22/19.

15. Resident #43's record documented there was a Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 5/4/19, which was not completed and transmitted as of 5/22/19.

16. Resident #21's annual MDS with an Assessment Reference Date (ARD) of 3/22/19 documented still in progress as of 5/23/19, 47 days after the ARD.

a. Resident #135's Admit MDS with and ARD of

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F 640	Continued From page 43 4/27/19 documented still in progress as of 5/23/19, 24 days after the ARD. b. Resident #4's Quarterly MDS with an ARD of 3/7/19 documented still in progress as of 5/23/19, 61 days after the ARD. c. Resident #23's Quarterly MDS with an ARD of 3/27/19 documented still in progress as of 5/23/19, 41 days after the ARD. d. Resident #19's Quarterly MDS with an ARD of 3/21/19 documented still in progress as of 5/23/29, 47 days after the ARD. e. Resident #13's Quarterly MDS with an ARD of 3/19/19 documented still in progress as of 5/23/19, 49 days after the ARD. f. Resident #12's Quarterly MDS with an ARD of 3/19/19 documented still in progress as of 5/23/19, 49 days after the ARD. g. Resident #16's Quarterly MDS with an ARD of 3/26/19 documented still in progress as of 5/23/19, 42 days after the ARD. h. Resident #10's Quarterly MDS with an ARD of 3/17/19 documented still in progress as of 5/23/19, 51 days after the ARD. i. Resident #27's Quarterly MDS with an ARD of 4/1/19 documented still in progress as of 5/23/19, 36 days after the ARD. j. Resident #8's Quarterly MDS with an ARD of 3/13/19 documented still in progress as of 5/23/19, 55 days after the ARD.	F 640		

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F 640	Continued From page 44 k. Resident #22's Quarterly MDS with an ARD of 3/26/19 documented still in progress as of 5/23/19, 42 days after the ARD. 17. On 05/23/19 at 11:11 AM, Registered Nurse (RN) #3 was asked, "How often are the resident assessments supposed to be completed and transmitted?" RN #3 replied, "92 days, and they should be transmitted 14 days after completion." RN #3 was asked, "Can you tell me why the resident assessments have not been completed?" RN #3 replied, "I have only been here maybe 30 days."	F 640		
F 641 SS=E	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure Minimum Data Set (MDS) assessments were accurate to facilitate care planning to meet resident needs for 2 (Residents #39, and #54) of 5 (Residents #39, 54, 55, 68 and 70) sampled residents who had a Level II Pre-Admission Screening and Resident Review (PASRR) completed. This failed practice had the potential to affect 10 residents who had a Level II PASRR completed, according to a list provided by the Administrator on 6/7/19. The findings are: 1. Resident #39 had a diagnosis of Major Depressive Disorder. Admission MDS with an ARD of 10/24/18 documented, "Is the resident currently considered by the state level II PASRR [Preadmission Screening and Resident Review]	F 641		

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F 641	Continued From page 45 process to have serious mental illness and/or intellectual disability ("mental retardation" in federal regulation) or a related condition?" The box for "No" was checked. 2. Resident #54 had diagnoses of Dementia in other diseases classified elsewhere with Behavioral Disturbance, Paranoid Schizophrenia, and Other Recurrent Depressive Disorders. The Admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 11/15/18 documented, "Is the resident currently considered by the state level II PASRR [Preadmission Screening and resident Review] process to have serious mental illness and/or intellectual disability ("mental retardation" in federal regulation) or a related condition?" The box for "No" was checked. A letter dated 12/12/18 from the state-designated PASRR screening provider documented a recommendation to include " ...Provision of a Structured Environment, mental health evaluation/diagnosis, master treatment plan, pharmacological review by physician, and periodic review of master treatment plan."	F 641		
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must-	F 655		

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F 655	Continued From page 46 (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interview, the facility failed to ensure a baseline care plan accurately reflected the resident's care needs to ensure continuity of care and resident	F 655		

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safety for 1 (Resident #278) of 1 case mix resident who was admitted to the facility in the past 30 days. This failed practice had the potential to affect 11 residents who were admitted to the facility in the past 30 days according to a list provided by the Administrator on 6/7/19. The findings are:

Resident #278 was admitted to the facility on 5/17/19 and had diagnoses of Non-ST Elevation Myocardial Infarction (NSTEMI), End Stage Renal Disease, and Chronic Ischemic Heart Disease. The entry Minimum Data Set dated 5/17/19 was not completed as of 5/23/19.

a. A Smoking Evaluation dated 5/17/19 documented, "...safe to smoke without staff assistance..."

b. A Medication Self-Administration Safety Screen dated 5/21/19 documented, "...May self-administer medications WITH SUPERVISION..."

c. On 05/19/19 at 04:04 PM, Resident #278 was sleeping with a CPAP (continuous positive airway pressure) in place. The resident stated, "I'm taking a nap can you come back later?"

d. On 05/20/19 at 11:19 AM, Resident #278 was in the smoking area. Resident reported, "I go to dialysis tomorrow and I have to see the doctor afterward and probably won't see you tomorrow." He was asked, "When you go to dialysis do they send a lunch with you?" He stated, "No, no, no. You sort of miss lunch. We leave at ten to go over and dialysis doesn't start until two. It's over at the hospital and some of the guys go down and eat in that cafeteria but the food is terrible over

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F 655	Continued From page 48 there, so I wait until I get back here ..." e. As of 5/23/19, the Care Plan dated 5/19/19 did not address pre and post-dialysis care / monitoring, smoking precautions, self-administration of medications or the use of CPAP. f. On 05/23/19 at 08:23 AM, the Director of Nursing (DON) was asked, "Was a baseline care plan developed and implemented within 48 hours of admission that included the minimum healthcare information necessary to properly care for the immediate needs of the resident?" She stated, "Probably not." g. On 05/23/19 at 10:24 AM, the DON was asked, "Should smoking be included on the baseline care plan?" She stated, "If we know they smoke, yes." She was asked, "Does [Resident #278] smoke?" She stated, "He does, but we didn't know he smoked at first [note: the initial smoking assessment was dated 5/17/19, the date of admission]. He came on Friday [5/17/19] and went LOA [leave of absence] with his family shortly after he got here, and when he came back on Monday [5/20/19], he wouldn't give us his cigarettes or medicines. So, when he came back, we did the assessment." She was asked, "Should the baseline care plan have been updated at that point?" She stated, "On Monday, yes."	F 655		
F 656 SS=E	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered	F 656		

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care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following -
(i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and
(ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).
(iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.
(iv)In consultation with the resident and the resident's representative(s)-
(A) The resident's goals for admission and desired outcomes.
(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.
(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.
This REQUIREMENT is not met as evidenced by:

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ARKANSAS STATE VETERANS HOME AT NORTH LITTLE ROCK	2401 JOHN ASHLEY DRIVE NORTH LITTLE ROCK, AR 72114

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Based on record review and interview the facility failed to ensure the Comprehensive Care Plan contained the necessary information to fully provide care and services for a resident who required mental health services and evaluation for 1 (Resident #54) of 48 (Residents #54, 65, 25, 16, 70, 26, 44, 38, 51, 9, 5, 55, 21, 39, 12, 4, 3, 10, 17, 6, 2, 76, 37, 78, 67, 77, 49, 56, 53, 60, 28, 20, 23, 22, 31, 59, 27, 19, 8, 30, 7, 68, 34, 13, 69, 75, and 43) who had a mental illness diagnoses; and failed to ensure the care plan addressed the precautions and monitoring necessary for a resident who received anticoagulation medication daily for 1 (Resident #32) of 8 (Residents #32, 45, 25, 38, 55, 39, 11 and 43) who had orders for anticoagulation medications). These failed practices had the potential to affect 75 residents who had a mental illness diagnoses and 12 residents who had orders for anticoagulant medication, according to lists provided by the Administrator on 6/7/19. The findings are:

1. Resident #54 had diagnoses of Dementia in other diseases classified elsewhere with Behavioral Disturbance, Paranoid Schizophrenia, and Other Recurrent Depressive Disorders. The Admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 11/15/18 documented, "Is the resident currently considered by the state level II PASRR [Preadmission Screening and Resident Review] process to have serious mental illness and/or intellectual disability ("mental retardation" in federal regulation) or a related condition? The box for "No" was checked.

a. A letter from the state-designated PASRR screening provider dated 12/12/18 documented a recommendation to include " ...Provision of a Structured Environment, mental health

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evaluation/diagnosis, master treatment plan, pharmacological review by physician, and periodic review of master treatment plan."

b. The Comprehensive Care Plan updated on 2/27/19 documented, "... [Resident #54] has an alteration in his psychosocial well-being d/t [due/to] his DX [diagnoses] of Dementia, Paranoid Schizophrenia and Depression with little to no interests in socialization or activities of past interests. Usually nonverbal and does not interact with others..." As of 5/21/19, the Care Plan did not address the state-designated PASRR screening provider's recommendation for a mental health evaluation.

c. On 05/23/19 at 09:13 AM, the Director of Nursing (DON) was asked, "Did you find a Mental Health evaluation?" She stated, "No, we weren't able to find anything."

2. Resident #32 was admitted to the facility on 5/15/18 and had diagnoses of Chronic Systolic (Congestive) Heart Failure, Obstructive Sleep Apnea (Adult) (Pediatric), Atherosclerotic Heart Disease of Native Coronary Artery without Angina Pectoris, and Presence of Automatic (Implantable) Cardiac Defibrillator. The Annual MDS with an ARD of 1/5/19 documented the resident received anticoagulant medication on 7 of the past 7 days.

a. A physician order dated 12/29/17 on the May 2019 Physician's Order listing documented, "...Rivaroxaban Tablet 20 MG [milligram] Give 1 tablet by mouth in the afternoon related to CHRONIC SYSTOLIC (CONGESTIVE) HEART FAILURE ... start date 12/29/17 ..."

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F 656	Continued From page 52 b. The Comprehensive Care Plan initiated on 1/9/18 and last reviewed on 10/12/18 had no documentation of anticoagulant use. c. On 5/23/19 at 9:25 a.m., the Director of Nursing was asked, "Should the Comprehensive Care Clan reflect anticoagulant medication?" She stated, "Yes. I would hope so."	F 656		
F 684 SS=E	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interview the facility failed to ensure a wound assessment was documented and physician orders for wound treatment were obtained to ensure continuity of care and promote healing for 1 (Resident #43) of 15 (Residents #15, 3, 20, 26, 32, 30, 9, 70, 45, 128, 56, 8, 27, 29, and 71) sampled residents who had non-pressure related wounds. The failed practice had the potential to affect 23 residents who had non-pressure related wounds, as documented on a list provided by the Director of Nursing (DON) on 5/23/19. The findings are: Resident #43 had a diagnoses of Chronic Obstructive Pulmonary Disease, Hypertension,	F 684		

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Systolic Congestive Heart Failure, Atrial Fibrillation, Diabetes Mellitus, and Cognitive Communication Deficit.

a. The Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 2/1/19 documented the resident had modified independence in cognitive skills for daily decision making per a Staff Assessment for Mental Status (SAMS), required extensive physical assistance of two persons for bed mobility and transfer, and had no documented falls and had a skin tear with treatment of application of non-surgical dressings.

b. The Progress Notes dated 5/15/19 at [5:48 p.m.] documented an Incident & Accident on 5/15/19 with a skin tear to the right forearm.

c. The Progress Notes dated 5/15/19 documented, "...Cleaned, applied steri strips, and covered skin tear with a non-adherent pad." There were no orders for wound treatment documented.

d. The Progress Notes dated 5/16/19 documented, "[Medical Doctor] rounded." There were no orders for wound treatment documented.

e. The Progress Notes dated 5/18/19 documented, "... [Resident #43] is on continued monitoring due to skin tear... Skin teat dressing intact at this time ..."

f. On 5/19/19 at 5:11 PM, there was a dressing dated 5/19/19 to the resident's right forearm. The surveyor took a photograph of the right forearm and dressing as this time. As of this date, there was no documentation of a wound assessment or

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F 684	Continued From page 54 physician order for wound care for the right forearm. g. The Progress Note dated 5/20/19 documented..."Skin tear to forearm. Clean and changed. Will continue to monitor..." h. On 05/22/19 at 09:30 AM the Director of Nursing (DON) was asked for treatment orders for the skin tear on Resident #43's right forearm. i. On 05/22/19 at 10:22 AM the DON stated, "The Advanced Practice Nurse (APN) looked at it and didn't want to do anything initially; they did steri strips and a dry dressing." j. On 05/22/19 at 02:05 PM the Director of Nursing (DON) was asked, "Can you provide the doctor order for skin tear treatment for [Resident #43] for the incident on 5/15/19?" The DON replied, "There are no orders, [Medical Doctor] said to monitor, we gave you everything we have." The DON was asked, "How do you know what to clean the wound with and dress the wound with?" The DON replied, "We don't have any orders."	F 684		
F 689 SS=E	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced	F 689		

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by:
Based on record review and interview, the facility failed to ensure fall prevention interventions were consistently develop and implemented to minimize the potential for injury for 1 (Resident #54) of 29 (Residents #2, 20, 18, 54, 39, 6, 3, 21, 24, 53, 12, 56, 27, 29, 16, 8, 28, 32, 48, 25, 22, 68, 43, 49, 77, 45, 71, 65, and 17) sampled residents who had falls in the past 6 months. These failed practices had the potential to affect 46 residents who had falls in the past 6 months, as documented on a list provided by the Administrator on 6/7/19.

The facility also failed to ensure clothes dryers remained free of lint build-up to decrease the potential for fire for 4 (Homes #1, 3, 6 and 8) of 8 (Hero Homes #1-#8) laundry rooms. This failed practice had the potential to affect 44 residents who resided in the 4 affected Hero Homes according to the Census by Cottages list dated 5/19/19. The findings are: The findings are:

1. Resident #54 admitted to the facility on 11/8/18 and had diagnoses of Dementia in other diseases classified elsewhere with Behavioral Disturbance, Paranoid Schizophrenia, and Other Recurrent Depressive Disorders. The Quarterly MDS with an ARD of 2/15/19 documented the resident had four falls, two with no injury, one with injury not major, and one with major injury.

a. An Incident Note dated 1/15/19 documented, "...Notified by... LPN that resident was found in room near chair, no distress noted. No s/s of pain. No visible bruising noted. Pt alert to self. Spouse notified. Resident sitting up to chair. Staff alerted to make sure pendent is in place. Resident sitting up in chair ... RN DON notified.

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APRN [Advanced Practice Registered Nurse] notified..." There was no documentation of new fall prevention intervention after the above fall.

b. An Incident and Accident (I&A) dated 1/15/19 documented, "Un-witnessed fall in room. Intervention 1:1; family and APRN notified. No injuries."

c. A Health Status Note dated 1/16/19 documented, "...Resident reporting pain all over when LPN entered dining area, LPN attempting to get vital signs and neurological check at around 07:00. Resident reports severe pain when LPN attempted to move right elbow. Resident refused vital signs at that time. Resident alert and oriented to self. Hand grasp equal, resident refused to open eyes at this time. Contacted RN Supervisor and informed of situation instructed to contact APRN. APRN ordered send to hospital via ambulance now. Informed RN Supervisor, DON, and family of order. Contacted [Ambulance Service #1] and informed of situation. UWs [Universal Workers] able to get vital signs at around 07:20. Vital signs within normal limits. Resident left via ambulance at 07:30. Will inform oncoming shift..." There was no documentation of new fall prevention intervention after the above fall.

d. A Health Status Note dated 1/16/19 documented, "...Resident returned via ambulance at around 09:50. Resident reports pain at that time, PRN [as needed] pain medication given per orders. Called [Outside Hospital #3] ER [emergency room] for report. Charge nurse reports full head to toe assessment completed, no pain reported in ER, no scrapes or abrasions noted. No new orders from ER at this time. Called

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APRN and informed of return and report from [Outside Hospital #3] ER. Called family and informed of return. PRN pain medication effective. Will continue current plan of care..." There was no documentation of new fall prevention intervention after the resident returned to the facility.

e. A Nurse's Note dated 1/18/19 documented, "...Resident had an unwitnessed fall in his room approximately at 1030 [10:30 a.m.] this morning. Resident was found in his room by [Universal Worker #26] sitting on his bottom between the chair and dresser with a puddle of urine on the floor. Resident was helped up by [Universal Worker #26] and [Universal Worker #27]. UW workers cleaned [Resident #54] and change his clothes. Resident denied any injury or pain, no visible bruises or lacerations noticed on client when assessed. Neurological assessment was started right after the fall at 1030. Vital signs include BP [blood pressure] 96/55, Pulse 76, Resp [respiration] 16, Temp [temperature] 97.8. Resident was alert, eyes PERRLA, [pupils equal, round, react to light and accommodation] hand grip equal in strength. Will continue to monitor resident. Called and informed resident's wife of the fall. Called and informed his daughter..." There was no documentation of new fall prevention intervention after the above fall.

f. An I&A dated 1/18/19 documented, "Un-witnessed fall in room. No injuries. Family and RN [Registered Nurse] supervisor notified. There were no documented fall prevention interventions.

g. The Comprehensive Care Plan updated on 2/27/19 documented, "....[Resident #54] is a

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HIGH potential for falls d/t [due to] his DX [diagnoses] of Dementia with little to no safety awareness; family reports strong hx [history]/of falls in the past 6 months; has had multiple falls since his admission here; use of Geri-chair with < [less than] daily use of tray with potential for restriction of movement; daily antidepressant as per MD [Medical Doctor] orders for DX of Depression; possible visual deficit d/t inability to follow command during visual acuity exam; potential for orthostatic hypotension, vertigo and or cardiac event. 12/26/18: family requesting Geri-chair be in reclined position in order to prevent [Resident #54] from leaning forward ... [Resident #54] to have no undetected fall through next review date... [Resident #54] to have no undetected injury r/t [related to] a fall through next review date... Assist [Resident #54] with sitting on the side of his bed for a few moments prior to transferring him... Bed in low and locked position... Frequent observation by staff d/t [Resident #54]'s inability to demonstrate proper use of call-pendant... Provide adequate lighting. Keep pathways clean and free of clutter... Wife has requested that [Resident #54] use his Geri-chair with a tray whenever he is out of his bed. Restraint consent to be signed and updated quarterly and prn... bed mobility assist: turn and reposition every 2 hours and prn [as needed]; currently up to extensive assist x1-2; assist as indicated. May use 1/4 side rails to promote independence with bed mobility as tolerated... Cushioned wedge behind his knees for proper positioning when up in his Geri-chair... Dysum to Geri-chair to help prevent sliding... Geri-chair to be in semi-Fowler's position, (approximately 45 degrees) to assist with proper positioning... Late entry for 11/30/2018: 1 hour safety checks Date Initiated: 12/13/2018... late entry for 11/30/2018:

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activity blanket Date Initiated: 12/13/2018...late entry for 11/30/2018: Dycem to geri-chair Date Initiated: 12/13/2018... Ensure brakes are locked on bed. Bed in lowest position ..."

h. An I&A dated 3/4/19 documented, "Un-witnessed fall in dining room. No injuries. Family and Physician notified." There were no documented interventions.

i. An Incident note dated 3/4/19 documented, "...Note Text: UW coming from restroom, noticed pt [patient] on floor. Called for help, I came to assist. Pt was laying [sic] on floor next to wheelchair in dining area. Assisted pt to wheelchair. Asked if he was hurt he said no, asked if he hit his head, he said no. Asked how he fell, he smirked and giggled a little. Vitals taken. Pendant present. Notified Wife, APRN [APRN #2], and RN supervisor..."

j. A Morse Fall Scale dated 3/4/19 documented, "...the resident scored 65 ... Morse Fall Scoring: High Risk 45 and higher..."

k. On 05/23/19 at 08:46 AM the ADON was asked, "How long was resident placed on 1:1 for fall on 1/15/19?" She stated, "It depends on the root cause analysis of the fall." She was asked, "What long term intervention was placed for the fall on 1/15/19?" She stated, "We sent him out to the ER, I know that is not long term but it is an intervention." The ADON was asked, "What intervention was implemented for the fall on 1/18/19?" She stated, "It looks like on 1/19/19 they got some lab on [resident]. They did neuro checks through the 19th and on the 20th they sent him to [Hospital #1] for eval [evaluation] of CT [computer tomography] of the head and noted

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a bruise on his hip." The DON was asked, "What intervention was implemented for the fall on 3/4/19?" She stated, "I don't see anything in the nurse's notes."

2. On 5/22/19 at 8:50 AM, during the Infection Control tour of each of the Laundry Departments with Registered Nurse (RN) #2, the following observations were made:

a. On 05/22/19 at 08:55 AM, in Home #1 the RN opened the dryer and cleaned out the lint trap. There was approximately 2 inches thick by 1 inch thick if lint in the lint trap. She cleaned the lint trap and turned the dryer back on. The surveyor took a photograph of the lint at this time.

b. On 05/22/19 at 08:59 AM, in Home #3 the surveyor looked behind the dryer and there was a towel behind the dryer sitting on the dryer vent. The surveyor took a photograph on the towel at this time. The RN was asked to look behind the dryer and tell what she saw. She stated, "It's a towel, if they got hot that would be a fire hazard."

c. On 05/22/19 at 09:13 AM, in Home #6 the dryer had a moderate amount of lint, approximately 1/2 inch thick on and around the vent pipe. The surveyor took a photograph of the vent pipe with lint at this time. The RN was asked, "How often do they sweep behind the dryers?" She stated, "They are supposed to do it every day at night shift, it looks like it hadn't been done".

d. On 05/22/19 at 09:18 AM, in Home #8 the surveyor tried look behind the dryer and could not. The dryer was pushed all the way up to the wall. The RN pulled the dryer out from the wall. There were socks behind the dryer and the vent

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F 689	Continued From page 61 pipe was kinked. The surveyor took a photograph of the socks and the vent pipe with a kink at this time. The RN retrieved the clothes from the back of the dryer and placed them on the counter. She was asked, "Can you tell me what that is?" She stated, "It's 3 pairs of sock and a placemat". The surveyor took a photograph of the socks and placemat at this time. The RN was asked, "Can you tell me what could happen with all those items behind the dryer?" She stated, "It could definitely catch fire". 3. The facility policy titled, "Laundry Guidelines" provided by the Administrator provided on 05/22/19 at 10:12 AM, documented, " ...The facility provides laundry and linen services to all patients in accordance with local, state, and federal rules, regulations and guidelines governing such services ... Drying Laundry and linens must be dried safely and properly. 1. Lint collection. a) Regardless of the make/model, all commercial dryers have a lint screen installed in the bottom component. This screen must be brushed out/cleaned every 2-3 loads. b) Although there is no screen installed in the top component, this area often fills with lint as well. The top panel must be opened, and this area cleaned DAILY to avoid lint collection in the heat source. c) Sometimes, lint will collect between the drum and sides of the dryer. The front of the dryer must be removed and the interior periodically vacuumed out ..." 4. On 05/22/19 at 03:03 PM, the Administrator was asked, "Should there be lint in the dryer and or around the outside dryer vent?" He stated, "No".	F 689		
F 725	Sufficient Nursing Staff	F 725		

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F 725 SS=F	Continued From page 62 CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure sufficient, competent nursing staff was present each shift to meet the supervision and care needs for residents in 8 of 8 Hero Homes (Homes #1 through #8), including 2 (Residents #6 and 71) of 2 residents who had orders for oxygen and / or nebulizer treatments. The failed practice had the	F 725		

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potential to affect all 85 residents who resided in the facility, as documented on the Resident Matrix provided by the Director of Nursing (DON) on 5/10/19. The findings are:

1. On 05/19/19 at 5:32 PM, in home 4, Universal Worker (UW) #4 was in the kitchen. She was asked if she was the only staff in the home and stated, "Yes."

a. On 05/19/19 at 05:35 PM, as the surveyor was walking from home 4 to home 3, Licensed Practical Nurse (LPN) #4 was entering home 4. She was asked if there was only one person in the home during meal service. She stated, "I'm helping her till 7 [7:00 p.m.], then someone else is coming in."

b. On 05/19/19 at 05:41 PM, LPN #4 entered Home #3 and stated, "I'm back; she was doing good."

c. On 05/19/19 at 05:46 PM, the surveyor went back to Home 4. UW #4 was serving the residents from the kitchen one at a time. She was still the only staff member in the home.

d. On 05/19/19 at 05:58 PM, while in Home 4 a staff member (unidentified) entered the home and stated, "I've never worked in here before."

2. On 05/21/19 at 09:30 AM, the spouse of Resident#67 stated, "There's not enough help... it takes 2 people to take her to the bathroom... It used to be they would answer the light within 5 minutes, now it's when they get to it... They just need more staff..."

3. On 05/21/19 at 01:15 PM, UW #18 was asked,

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"Is there enough staff to take care of the residents?" She stated, "In my opinion, no." If it is someone that's 2 person [assist] we need 2 people on the floor and one in the kitchen..." She was asked, "Is one person in a home during mealtime okay?" She stated, "...Never..."

4. On 05/21/19 at 01:33 PM, UW #20 was asked if there is enough staff in the home to take care of the residents. She stated, "Not for one person... we have 2 assist and people we have to watch, or if someone is cooking you can't leave it to go help; another resident could come in the kitchen or it could take longer and burn the food..."

5. On 05/19/19 at 04:09 PM, Resident #24, whose Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 12/28/18, documented the resident scored 15 (13-15 indicates cognitively intact) on the Brief Interview for Mental Status and required extensive assistance with activities of daily living (ADLs), stated, "They need more help here. Sometimes when they go on break, if something happened to two or three of us, no one would be here to help us, it would be dangerous. They have the agency nurses, and they just don't seem to care how I feel."

6. On 05/19/19 at 04:55 PM, Resident #29, whose Significant Change Minimum Data Set (MDS) with an Assessment Reference Date of 12/19/18, documented the resident scored 15 (13-15 indicates cognitively intact) on the Brief Interview for Mental Status (BIMS) and required supervision to limited assistance with ADLs, stated, "They don't have enough help around here, they have different ones to take care of you and it's usually agency, if something bad

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happened here, they couldn't help us because the nurse is always in the other house."

7. Resident #71 had diagnoses of Heart Failure, Hemiplegia, Hemiparesis, Hypertension, Pulmonary Fibrosis, Atherosclerosis of Native Coronary Artery of Transplanted Heart, and Bilateral Osteoarthritis of Knee. The Quarterly Minimum Data Set (MDS) with an Assessment Reference Date of 4/10/19, documented the resident scored 14 (13-15 indicates cognitively intact) on the Brief Interview for Mental Status, required extensive physical assistance of two persons for bed mobility and transfer, and had no documented oxygen use.

a. A Care Plan with a revision date of 7/25/18 documented,
"Has an alteration in his ADL [activity of daily living] functions d/t [due to] DX [diagnosis] of Pulmonary Fibrosis and is now on Hospice with prognosis of < [less than] 6 months with increased episodes of SOB [shortness of breath] and need for O2 [oxygen] as per MD [Medical Doctor] orders... Oxygen therapy as per MD orders. Oxygen @ [at] 2L/M [liters per minute] nasal cannula continuous."

b. A Physician Order dated 4/5/19 documented, "Oxygen @ 4 L/min via nasal cannula PRN. May increase up to 6 L PRN for pulse OX [oximeter] below 90% as needed related to Pulmonary Fibrosis, Unspecified..."

c. On 05/20/19 at 08:34 AM, Resident #71 was asked, "Do you think there is enough staff here to help you?" Resident #71 stated, "There are moments when there could be more."

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d. On 05/20/19 at 08:41 AM, Resident #71 complained of shortness of breath and yelled for UW #1 to come to the day room where he was sitting in an electric wheelchair. Resident #71 was mouth breathing and visibly short of breath. UW #1 came over to resident, looked at the portable 02 tank on back of Resident #71 chair, and then left the area to look for the nurse.

e. On 05/20/19 at 08:42 AM, UW #1 returned to Resident #71 and stated, "The nurse is in Home 1. Can we go to your room and get on your oxygen in your room?" Resident #71 guided his electric chair to his room.

f. On 05/20/19 at 08:43 AM, UW #1 applied gloves, removed the nasal cannula from Resident #71 face/nostrils. UW #1 then picked up the nasal cannula from Resident #71 bed and applied it to Resident #71 nostrils/face. The oxygen concentrator was running at 5 liters per minute.

g. On 05/20/19 at 08:45 AM, UW #1 was asked, "Did you remove the nasal cannula from Resident #71 and place the nasal cannula from the bed on Resident #71?" UW #1 replied, "I might have, I meant to give it to him, but I wanted to make sure he had oxygen." UW #1 was asked, "Are you supposed to remove and apply oxygen on residents?" UW #1 replied, "No." UW #1 was asked, "Do you have a nurse on duty full time here?" UW #1 replied, "She floats between two houses."

h. On 05/20/19 at 08:49 AM, Resident #71 was asked, "How is your breathing now?" Resident #71 replied, "It's better, I got on the concentrator."

i. On 05/20/19 at 08:58 AM, LPN #3 entered

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Resident #71's room and begins taking vital signs. Resident #71 oxygen saturation was 89%.

j. On 05/20/19 at 09:00 AM, Registered Nurse (RN) #1 entered the room and told LPN #3, "I've got this, go pass your medications." Resident #71 oxygen saturation was reading 91% on 5 liters per minute of oxygen at this time. RN #1 was asked, "Are Universal Workers supposed to remove and apply oxygen to the residents?" RN #1 replied, "Nurses normally do it, normally we are here." RN #1 was asked, "What happens if there is an emergency with a resident's breathing?" RN #1 replied, "Respiratory distress." RN #1 stated, "This going between two houses is a new thing."

k. On 05/21/19 at 09:05 AM, LPN #1 was asked, "Who is supposed to administer and remove oxygen on the residents?" LPN #1 replied, "The nurse."

l. On 05/21/19 at 09:07 AM, LPN #2 was asked, "Who is supposed to administer and remove oxygen on the residents?" LPN #2 replied, "The nurses."

m. On 05/21/19 at 09:14 AM, UW #2 was asked, "Who is supposed to administer and remove oxygen on the residents?" UW #2 replied, "The nurse."

n. On 05/21/19 at 09:15 AM, UW #3 was asked, "Who is supposed to administer and remove oxygen on the residents?" UW #3 replied, "The nurse."

o. On 05/21/19 at 09:18 AM, UW #1 was asked, "Who is supposed to administer and remove

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oxygen on the residents?" UW #1 replied, "The nurse."

8. On 05/20/19 at 09:46 AM, Resident #7, whose Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 12/13/18 documented the resident scored 15 (13-15 indicates cognitively intact) on the Brief Interview for Mental Status and required supervision for some ADLs, was asked, "Do you feel they have enough staff to take care of you?" Resident #7 replied, "No, especially on the third shift." Resident #7 was asked, "Have you ever needed a nurse and had to wait on one?" The resident stated, "Yes, especially since they work two houses, on third shift there should be 2 Universal Workers on duty, 'cause if she needs help to turn someone, she needs help, and they usually just have one Universal Worker on duty and she could get hurt."

9. On 05/20/19 at 10:12 AM, Resident #6, whose Annual Minimum Data Set (MDS) with an Assessment Reference Date of 12/11/18 documented the resident scored 14 (13-15 indicates cognitively intact) on a Brief Interview for Mental Status and required supervision with some ADLs, was asked, "Do you think they have enough staff here to take care of you?" Resident #6 replied, "No, no." At 10:14 AM, Resident #6 stated, "I asked where the nurse was at breakfast, and they said she was working the other buildings; I wish they would get me my nebulizer."

10. On 05/21/19 at 09:05 AM, LPN #1 was asked, "Should there be a nurse in each house at all times in case of an emergency?" LPN #1 replied, "Yes." LPN #1 was asked, "Have you ever worked

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shorthanded?" LPN #1 replied, "Yes."

At 09:07 AM, LPN #2 was asked, "Should there be a nurse in each house at all times in case of an emergency?" LPN #2 replied, "Yes." LPN #2 was asked, "Have you ever worked shorthanded?" LPN #2 replied, "Yes."

At 09:14 AM, UW #2 was asked, "Should there be a nurse in each house at all times in case of an emergency?" UW #2 replied, "Yes, I would think so." UW #2 was asked, "Have you ever worked shorthanded?" UW #2 replied, "Yes."

At 09:15 AM, UW #3 was asked, "Should there be a nurse in each house at all times in case of an emergency?" UW #3 replied, "Yes." UW #3 was asked, "Have you ever worked shorthanded?" UW #3 replied, "Yes."

At 09:18 AM, UW #1 was asked, "Should there be a nurse in each house at all times in case of an emergency?" UW #1 replied, "Yes, especially the Veterans that have oxygen?" UW #1 was asked, "Have you ever worked shorthanded?" UW #1 replied, "Yes."

11. On 05/20/19 at 01:56 PM, a group meeting was conducted with 6 alert and oriented residents from various cottages. (Resident #34 from Cottage 7, Resident #51 from Cottage 1, Resident #29 from Cottage 2, Resident #21 from Cottage 4, Resident #38 from Cottage 6 and Resident #16 from Cottage 3). All the residents complained about agency staff waking them up to give them the medications and then leaving the cottage. Individual residents also made the following comments:

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F 725	Continued From page 70 "The problem is just one nurse for two cottages and you have to wait for assistance ... Lots of times there will be just one nurse and one universal worker in a cottage ..." " ...We believe there should be one nurse for one cottage ... If there was an emergency you would die before the nurses got to you ..." " ...Our medicine is late a lot of the times because they don't have enough staff ... The staff are continually changing ... You never know who is going to be here and who is not ..." 12. On 05/21/19 at 12:20 PM, the Surveyor reviewed the minimum staffing reporting form for the last 90 days (February, March and April of 2019). On February 5th and 6th, the facility was short 1 staff on the evening shift. On February 9th and 10th, the facility was short 1 staff on the evening shift. On February 22nd the facility was short 1 staff on the evening shift. On February 27th and 28th the facility was short 1 staff on the day shift and 1 staff on the evening shift. 13. On 5/23/19 at 3:00 p.m., the Ombudsman entered the facility and spoke with the Surveyor. She stated, "The residents don't feel like they are getting the help they were promised. The staff are doing multiple jobs".	F 725		
F 726 SS=E	Competent Nursing Staff CFR(s): 483.35(a)(3)(4)(c) §483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest	F 726		

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practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e).

§483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care.

§483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs.

§483.35(c) Proficiency of nurse aides.
The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care.
This REQUIREMENT is not met as evidenced by:
Based on observation, record review and interview, the facility failed to ensure Universal Workers (non-licensed nursing staff) performed only duties for which they were trained and competent, as evidenced by the administration of oxygen therapy by Universal Workers, which had the potential to result in incorrect administration and respiratory complications 2 (Residents #43 and #71) of 4 (Residents #6, #24, #43 and #71) sampled residents who had a physician order for oxygen therapy. This failed practice had the potential to affect 7 residents who had a physician

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order for oxygen therapy, as documented on a list provided by the Director of Nursing on 5/22/19 at 1:55 PM. The findings are:

1. Resident #71 had diagnoses of Heart Failure and Pulmonary Fibrosis

a. The Quarterly Minimum Data Set (MDS) with an Assessment Reference Date ARD of 4/10/19 documented the resident scored 14 (13-15 indicates cognitively intact) on a Brief Interview for Mental Status (BIMS), required two-plus persons extensive physical assistance for bed mobility, transfer, dressing, toilet use, and personal hygiene, and no documented oxygen therapy.

b. A Care Plan problem with a revision date of 7/25/18 documented, " ...Oxygen @ [at] 2L/M [liters per minute] nasal cannula continuous (updated 1/11/2019) ..."

c. A physician order dated 4/5/19 documented, "...Oxygen @ 4 L/min [liters per minute] via nasal cannula PRN [as needed]. May increase up to 6 L [liters] PRN for pulse OX [pulse oximeter reading - oxygen saturation] below 90% as needed..."

d. On 5/20/19 at 8:41 a.m., Resident #71 complained of shortness of breath and yelled for Universal Worker (UW) #1 to come to the day room, where he was sitting in an electric wheelchair. Resident # 71 was mouth breathing. UW #1 approached the resident, looked at the portable oxygen (O2) tank on back of Resident #71's chair and left the area to look for the nurse.

e. On 5/20/19 at 08:42 a.m., UW #1 returned to Resident #71 and stated, "The nurse is in Home

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1. Can we go to your room and get on your oxygen in your room?" Resident #71 guided his electric chair to his room.

f. On 5/20/19 at 8:43 a.m., UW #1 was in Resident #71's room, put on gloves and removed the nasal cannula from the resident's face/nostrils. UW #1 picked up the nasal cannula from the resident's bed and applied the oxygen tubing to the resident's nostrils/face. The oxygen concentrator was set at 5 liters per minute.

g. On 05/20/19 at 08:45 a.m., UW #1 was asked, "Did you remove the nasal cannula from [Resident #71] and place the nasal cannula from the bed on [Resident # 71]?" UW #1 stated, "I might have. I meant to give it to him, but I wanted to make sure he had oxygen." UW #1 was asked, "Are you supposed to remove and apply oxygen on residents?" UW #1 stated, "No." UW #1 was asked, "Do you have a nurse on duty full time here?" UW #1 stated, "She floats between two houses."

h. On 5/20/19 at 8:49 a.m., Resident #71 was asked, "How is your breathing now?" Resident #71 stated, "It's better. I got on the concentrator."

i. On 5/20/19 at 8:58 a.m., LPN #3 entered the resident's room and took vital signs. Resident #71's oxygen saturation was 89% [percent].

j. On 5/20/19 at 9:00 a.m., Registered Nurse (RN) #1 entered the room and told LPN #3, "I've got this, go pass your medications". Resident # 71 oxygen saturation was reading at 91% on 5 liters per minute of oxygen at this time. RN #1 was asked if the UWs were supposed to remove and apply oxygen to the residents and stated, "Nurses

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normally do it. Normally we are here." RN #1 was asked, "What happens if there is an emergency with a resident's breathing?" RN #1 stated, "Respiratory distress. This going between two houses is a new thing."

2. Resident #43 had diagnoses of Chronic Obstructive Pulmonary Disease (COPD) and Systolic Congestive Heart Failure (CHF).

a. The Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 2/1/19 documented the resident had modified independence in cognitive skills for daily decision making per a Staff Assessment for Mental Status (SAMS), required two-plus persons extensive physical assistance for bed mobility, transfer and toilet use and no documented oxygen therapy.

b. A Care Plan problem with a revision date of 8/8/18 documented, "...has an alteration in his gas exchange d/t [due to] DXs [diagnosis] of COPD and CHF with potential for SOB [shortness of breath] requiring O2 [oxygen] as per MD [medical doctor] orders and potential for complications r/t [related to] respiratory distress... OXYGEN SETTINGS: O2 via [by way of] nasal cannula @ [at] 2L [2 liters]..."

c. A physician order dated 4/5/19 documented, "...Oxygen @ 2 L/min [liters per minute] via nasal cannula PRN [as needed

d. On 5/20/19 at 10:45 a.m., Universal Worker (UW) #4 entered Resident #43's room. UW #4 placed the nasal cannula in the resident's nostrils. UW #4 was asked, "Are you supposed to apply oxygen to the residents?" UW #4 stated, "We do it. I was never told not to."

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F 726	Continued From page 75 3. On 5/21/19 at 9:05 a.m., Licensed Practical Nurse (LPN) #1 was asked, "Who is supposed to administer and remove oxygen on the residents?" LPN #1 stated, "The nurse." 4. On 5/21/19 at 9:14 a.m., UW #2 was asked, "Who is supposed to administer and remove oxygen on the residents?" UW #2 stated, "The nurse." 5. On 5/22/19 at 9:18 a.m., the Director of Nursing (DON) was asked, "Who is responsible for applying and removing oxygen from a resident?" The DON stated, "I'm not sure." The DON was asked, "Do you have a policy on oxygen administration. The DON replied, "I'm going to say we don't have one."	F 726		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and	F 812		

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serve food in accordance with professional standards for food service safety.
This REQUIREMENT is not met as evidenced by:
Based on observation and interview, the facility failed to ensure food stored in the refrigerator, freezer and storage areas were covered, sealed, labeled, dated and used or disposed of, on or by the "best by" or expiration dates; food that required refrigeration was maintained at or below 41 degrees Fahrenheit (F.) and universal workers washed their hands and changed gloves between dirty and clean tasks and before handling clean equipment or food items to minimize the potential for food borne illness for residents who received meals from 8 of 8 kitchens. The failed practices had the potential to affect 85 residents who received meals from the 8 kitchens (total census: 85), as documented on a list provided by the Director of Nursing (DON) on 5/22/19. The findings are:

1. On 5/19/19 at 2:15 p.m., the following observations were made in the kitchen in Home 1.

a. The refrigerator temperature was 51 degrees Fahrenheit [F]. Universal worker #1 was asked by the surveyor to test the temperature of a gallon of whole milk that was half full in the refrigerator. He did so, and the thermometer read 49 degrees Fahrenheit (F.). Universal Worker #1 stated, "We have been going in and out of the refrigerator."

b. There were open bags of shredded lettuce, ham slices, bacon, squash and a zip lock bag of hot dogs stored in a compartment in the refrigerator that were not sealed.

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c. An open pan of icing was stored on a shelf in the refrigerator and it was not sealed.

d. There were open zip lock bags that contained breaded okra, pork chops, yeast rolls, biscuits and onion rings stored in a compartment in the freezer that were not sealed.

e. There was a quart of butter milk, with an expiration date of 4/4/19 on the label, stored on a shelf in the refrigerator.

f. A gallon of whole milk, with an expiration date of 5/15/19 on the label, was stored on a shelf in the refrigerator.

g. There was a 24 [ounce] (oz) container of pimento cheese, with an expiration date of 4/30/19 on the label, on a shelf in the refrigerator.

h. A 5-pound (lb.) container of potato salad, with an expiration date of 5/8/19 on the label, was on a shelf in the refrigerator.

i. A zip lock bag that contained cake mix was on a shelf in the storage room with no date on the bag.

j. There was a 5-pound box of cake mix, with an expiration date of 2/11/19 on the label, on a shelf in the storage room.

k. An open box of Cheerios was on a shelf in the storage room and was not covered or sealed. An open 25 lb. bag of all-purpose flour and an open 25 lb. bag of sugar were on a shelf in the storage room and were not sealed.

2. On 5/20/19 at 11:12 a.m. in Home 1, Agency Universal Worker #12 was wearing gloves and

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removed a tray from the cabinet and placed it on the counter. Without changing her gloves, she put her fingers inside glasses, picked them up and placed them on the trays to be used to serve beverages to the residents during the lunch meal service. She put her fingers inside a bowl, picked it up and placed it on the counter to be used in portioning food items to be served to the residents during the lunch meal service.

3. On 5/20/19 at 11:15 a.m., in Home 1, Agency Universal worker #13 was wearing gloves and picked up a bag of ice and hit it inside the sink to break the ice loose. Without changing her gloves, she used her gloved hand to remove ice cubes from the bag and placed them in the glasses to be used in serving beverages to the residents during the lunch meal service.

4. On 5/19/19 at 3:33 p.m., the following observations were made in the kitchen in Home 3:

a. The temperature of the refrigerator was 45 degrees Fahrenheit. Universal Worker #2 was asked by surveyor to test the temperature of a gallon of whole milk that was half full, in the refrigerator. He did so, and the thermometer read 48 degrees Fahrenheit. Universal Worker #2 stated, "We have been going in and out of the refrigerator using the milk."

b. A 32 fluid oz container of heavy whipping cream, with an expiration date of 5/5/19 on the label, was stored on a shelf in the refrigerator.

c. A quart of buttermilk, with an expiration date of 4/4/19 on the label, was on a shelf in the refrigerator.

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d. A plastic container with loose, discolored strawberries was on a shelf in the refrigerator. Universal Worker #2 was asked to describe the appearance of the fruit. He stated, "They are bruised." There was no date on the container to indicate how long the strawberries had been in the refrigerator.

e. A 32 fluid ounce (oz) bottle of lemon juice, with an expiration date of 3/31/19 on the label, was stored on a shelf in the refrigerator.

f. An open bag of hot dogs was stored in a compartment in the freezer and was not sealed

g. A 5 lb. bag of self-rising flour was on a shelf in the storage room. The bag was not sealed.

h. A 5 lb. box of pound cake mix, with an expiration date of 11/21/18 on the label, was on a shelf in the storage room.

5. On 5/20/19 at 9:24 a.m., in Home 3, Universal Worker #9 used a paper towel to wipe off spilled water around the hand washing sink. Without washing her hands, she picked up a clean plate to be used to serve a lunch meal to a resident. With her fingers touching the inside of the plate, she placed it on a rack. At 9:46 a.m., Universal worker #9 used a paper towel to wipe around her mouth. Without washing her hands, she touched lettuce leaves that she had rinsed and left in the colander to drain. At 9:50 a.m., removed a marker from the drawer and wrote dates on the saran wraps that were used to cover 2 pitchers that contained tea, to be served to the residents during the lunch meal service. At 9:51 a.m., without washing her hands, she put on (donned)

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gloves and tore the lettuce leaves and placed the pieces into a bowl. At 9:52 a.m., she removed her gloves, took out a sheet of paper liner and placed it on the counter. She removed a peeler from the drawer and used it to peel a cucumber. At 9:54 a.m., she opened the dish washing machine, removed a clean pot and placed it in the cabinet with her fingers touching inside the pot. She picked up a knife from the drawer and laid it on the cutting board that was on the counter. She wiped off spilled water from the counter with a paper towel. She covered the bowl of lettuce leaves with saran wrap and placed it on a shelf in the refrigerator. At 9:58 a.m., she picked up gloves and placed one on her left hand. She used her right hand to open the refrigerator door but did not remove anything. She placed the other glove on her right hand and sliced a cucumber. At 10:01 a.m., she opened the refrigerator and removed the bowl of lettuce leaves and placed it on the counter. She placed slices of cucumber on the lettuce leaves. She sliced a tomato and put the slices on the salad. At 10:03 a.m., she removed a tomato from the refrigerator, rinsed it and placed it on the cutting board. She removed the gloves from her hands and discarded them. Without washing her hands, donned clean gloves. She sliced the tomato, placed it on the salad and mixed it [the salad] to be served to the residents for the lunch meal.

6. On 5/19/19 at 3:54 p.m., the following observations were made in the kitchen in Home 2:

a. An open 15 oz bottle of vanilla caramel coffee creamer was stored in the refrigerator door handle compartment and it was not covered.

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b. An open zip lock bag that contained peeled carrots and a cucumber was in a compartment in the refrigerator and it was not sealed.

c. A container of chicken salad, with a 'use by' date of 5/15/19, was stored on a shelf in the refrigerator.

d. An open bag of breaded okra and an open bag of onion rings were in a compartment in the freezer and they were not sealed. A carton of vanilla ice cream was on a shelf in the freezer. There was gray matter at the center of the ice cream. Universal Worker #3 was asked to describe the appearance of the ice cream. She stated, "That was gray matter on the ice cream."

7. On 5/19/19 at 4:09 p.m., the following observations were made in the storage room in Home 2:

a. There were 11 open glasses, which contained frozen ice cubes, in the freezer and were not sealed. Universal Worker #3 was asked what were the glasses of ice used for. She stated, "They are for residents' beverages for supper."

b. A 16.3 oz buttermilk flaky biscuit tube, with an expiration date of 3/27/19 on the label, was stored inside the refrigerator door handle.

c. A container of cooked beans was on a shelf in the refrigerator. There was no date on the container to indicate when the beans had been placed there.

d. An 8.3 oz container of cheesecake, with an expiration date of 3/14/19 on the label, was on a shelf in the refrigerator.

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e. A 5 lb. carton of cultured sour dressing, with an expiration date of 5/17/19 on the label, was on a shelf in the refrigerator.

f. A 25 lb. bag of sugar and a 25 lb. bag of self-rising flour were on a shelf in the storage room and they were not sealed.

8. On 5/19/19 at 4:24 p.m., the following observations were made in the kitchen in Home 4:

a. An open bag of bacon was in a compartment in the refrigerator and it was not sealed.

b. A cup of pudding was on a shelf in the freezer and it was not dated.

c. An open bag of tater tots and French fries were in a compartment in the freezer and they were not sealed.

9. On 5/19/19 at 4:35 p.m., the following observations were made in the Storage room in Home 4:

a. There were 10 open glasses, which contained ice cubes, in the freezer that were not covered. Universal worker #4 stated, "They are for residents' beverages for dinner."

b. A 5 lb. carton of cultured sour dressing, with an expiration date of 5/2/19 on the label, was on a shelf in the refrigerator.

c. An open bag of brown sugar was on a shelf in the storage room and it was not sealed. There were six-15 oz boxes of raisins, with an expiration

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date of 11/27/18 on the label, on a shelf in the storage room.

d. An open box of cornstarch and a 15.2 oz box of yellow cake mix was on a shelf in the storage room and they were not covered or sealed. There were two-35 oz bags of toasted oats, one-18.2 oz bag of raisin bran and a 16 oz bag of wavy rippled potato chips was on a shelf in the storage room and they were not covered or sealed.

10. On 5/19/19 at 4:54 p.m., the following observations were made in the kitchen in Home 5:

a. There were six-16 oz bottles of crystal juice on a shelf in the refrigerator. There were no dates on the bottles to identify when they were received.

b. There was a 32 oz bag of corn nuggets, a 32 oz bag of carrots and a 44 oz bag of onion rings in a compartment in the freezer and they were not sealed.

c. An open bag of stew meat, that had areas that were grey and dried in appearance, was in a compartment in the freezer and was not sealed Universal Worker #5 stated, "It has freezer burn, and that's messed up."

d. There was a bottle, of 8 fluid oz of Vitamin A and D milk fat free milk on a shelf in the refrigerator. The label had an expiration date of 4/30/19.

g. A 5 lb. container of cottage cheese, with an expiration date of 3/18/19 on the label, was stored on a shelf in the refrigerator.

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h. A 5 lb. box of cultured sour dressing was on a shelf in the refrigerator and it was not covered.

i. A box of [food delivery service] imperial raisins, with an expiration date of 11/27/18 on the label, was on a shelf in the storage room.

11. On 5/19/19 at 5:16 p.m., the following observations were made in the kitchen in Home 6:

a. A 32 fluid oz carton of heavy whipping cream, with an expiration date of 5/5/19 on the label, was on a shelf in the refrigerator.

b. A 32 oz bag of toasted oats was on a shelf in the refrigerator and it was not sealed.

12. On 5/20/19 at 10:19 a.m., in Home 6, Universal Worker #10 was wearing gloves and she turned on the hand washing faucet and rinsed a boiled egg. Without changing gloves or washing her hands, she sliced an egg and placed it on a salad. She stated, "It had a piece of egg shell on it ..."

13. On 5/19/19 at 5:47 p.m., the following observations were made in the kitchen of Home 7:

a. A 32 fluid oz carton of heavy whipping cream, with an expiration date of 5/5/19 on the label, on a shelf in the refrigerator.

b. A box of home-grown eggs, not dated, were in a compartment in the kitchen. A 16 oz bottle of pickles, with an expiration date of 3/19 on the label, was on a shelf in the refrigerator

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c. An open bag of French toast, a bag of onions rings, a bag of fries, a bag of tater tots and a bag of breaded okra were in a compartment in the freezer and they were not sealed.

14. On 5/19/19 at 5:58 p.m., the following observations were made in the freezer in the storage room in Home 7:

a. An open zip lock bag of hot dogs was on a compartment in the freezer and it was not sealed.

b. A carton of cultured sour dressing, with an expiration date of 5/16/19 on the label, was on a shelf in the refrigerator in the storage room.

c. There was a container of slaw, with an expiration date of 4/17/19 on the label, on a shelf in the refrigerator.

d. A container of unidentified soup was on a shelf in the refrigerator. There was no date on it to indicate how long it could be used.

e. An open box of grits was on a shelf in the storage room. The box was not covered or sealed. An open box of cream of wheat was on a shelf in the storage room and it was not sealed.

15. On 5/19/19 at 6:11 p.m., the following observations were made in the kitchen in Home 8:

a. A 32 fluid oz carton of heavy whipping cream, with an expiration date of 5/5/19 on the label, was on a shelf in the refrigerator.

b. A quart of buttermilk, with an expiration date of 4/4/19 on the label, was stored on a shelf in the

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refrigerator.

c. A 3 lb. box of cream cheese, with an expiration date of 1/7/19 on the label, was stored on a shelf in the refrigerator.

16. On 5/19/19 at 6:18 p.m., the following observations were made in the refrigerator in the storage room in Home 8.

a. A quart of buttermilk, with an expiration date of 4/4/19 on the label, was stored on a shelf in the refrigerator.

b. A 5 lb. container of pimento cheese spread, with an expiration date of 4/20/19 on the label, was stored on a shelf in the refrigerator.

c. A 5 lb. container of redskin potato salad, with an expiration date of 5/8/19 on the label, was on a shelf in the refrigerator.

d. A box of baking soda, with an expiration date of 9/29/18 on the label, was on a shelf in the storage room.

e. A 12 oz box of crisp rice toasted oats cereal was on a shelf in the storage room and it was not covered or sealed.

17. On 5/20/19 at 10:35 a.m., in Home 8, Universal Worker #11 donned a pair of gloves and removed a glass from the cabinet. She turned on the faucet, obtained water in the glass and placed it on the counter. She removed a can of seasoning the cabinet and laid it on the counter. She removed a clean dish rack, with clean dishes, from the dish machine and laid it on the counter. Without changing her gloves, she

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045462	A. BUILDING _____ B. WING _____	05/23/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARKANSAS STATE VETERANS HOME AT NORTH LITTLE ROCK	2401 JOHN ASHLEY DRIVE NORTH LITTLE ROCK, AR 72114

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 812	Continued From page 87 picked up the clean dishes with her fingers touching inside the dishes and placed them in the cabinet to be used in portioning food items to be served to the residents for the lunch meal service. She picked up glasses by their rims and placed them in the cabinet to be used in serving beverages to the residents for the lunch meal service. 18. On 5/20/19 at 1:00 p.m., 6 alert and oriented residents who participated in a group interview stated, "The Universal [worker] take care of you and then cook your meals. They will serve you without washing their hands."	F 812		
F 867 SS=F	QAPI/QAA Improvement Activities CFR(s): 483.75(g)(2)(ii) §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure Quality Assessment and Assurance (QAA) promptly implemented measures to correct problems with lack of sufficient competent staff and late Minimum Data Set (MDS) assessments and followed up to ensure the corrective efforts were successful, to assure residents' care and safety needs were met in 8 of 8 Hero Homes (#1 through #8). These failed practices had the potential to affect all 85 residents who resided in the facility, as documented on the Resident Census and Conditions of Residents form dated 5/20/19. The	F 867		

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F 867	Continued From page 88	F 867		

findings are:

1. The facility's QAPI (Quality Assurance and Performance Improvement) Project Charter provided by the Administrator on 05/20/19 at 8:00 AM, documented, " ...Name of Project Improve MDS Process ... Problem to be solved: To ensure compliance with regulatory requirements and to better serve our residents through improved care planning ... The goal(s) for this project: ...A current attempt is in progress to hire an MDS Coordinator on an emergency hire basis and we should know whether or not this attempt has been successful by the end of business today 4/4/2019.

a. During the survey conducted from 5/20/19 through 5/23/19, a pervasive problem with inaccurate and late completion and transmittal of MDS assessments was identified. Refer to tags F636, F637, F638, F640, and F641 for further details.

b. On 5/21/19 at 9:25 AM, the Director of Nursing (DON) was asked if she had any documentation of monitoring of the progress with the MDS and care plans. She stated, "We review it weekly, but I do not have any weekly documentation of what we discussed."

c. On 5/21/19 at 9:30 AM, the Administrator was asked, "Do you have any documentation to show ... monitoring of the progress with the MDS and care plans?" He stated, "No, we do not".

2. On 05/20/19 at 1:56 PM, a group meeting was conducted with 6 alert and oriented residents from various cottages. (Resident #34 from Cottage 7, Resident #51 from Cottage 1,

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F 867	Continued From page 89	F 867		

Resident #29 from Cottage 2, Resident #21 from Cottage 4, Resident #38 from Cottage 6 and Resident #16 from Cottage 3) All the residents complained of agency staff waking them up to give them the medicine and then leaving. Their other comments included: " ...the problem is just one nurse for two cottages and you have to wait for assistance ... Lots of times there will be just one nurse and one universal worker in a cottage ... We believe there should be one nurse for one cottage ... If there was an emergency you would die before the nurses got to you ... Our medicine is late a lot of the times because they don't have enough staff ... The staff are continually changing ... You never know who is going to be here and who is not ..."

a. During the survey conducted from 5/20/19 through 5/23/19, a pervasive problem with sufficient staffing was identified. Refer to tag F725 for further details.

b. On 5/21/19 at 1:00 p.m., the DON and the Administrator were asked if the Quality Assurance Committee had identified issues with staffing. They both stated, "It was before their time."