STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045409	A. Building B. Wing	12/11/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Prairie Grove Health and Rehabilitation, LLC	621 South Mock Street Prairie Grove, AR 72753

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure fingernails were trimmed, cleaned, and free of jagged edges to promote good personal hygiene and grooming for 1 (Resident #15) of 1 sampled resident. This failed practice had the potential to affect 15 residents who were dependent on staff for nail care according to a list provided by Director of Nursing on 12/10/2020 at 11:51 A.M. The findings are: Resident # 15 had [DIAGNOSES REDACTED]. The Quarterly Minimum Data Set with an Assessment Reference Date of 11/29/2020 documented the resident scored 8 (8-12 indicates moderately impaired) on a Brief Interview for Mental Status and required extensive assistance with transfers, toileting, dressing, personal hygiene, and was independent with eating. a. The Care Plan with a start date of 11/30/2020 documented, . Focus: ADL (Activities of Daily Living) self-care deficit rt (related to) Dementia, impaired balance, limited mobility and [MEDICAL CONDITION] . Interventions . PERSONAL HYGIENE/ORAL CARE: requires ext. (extensive) 1 staff participation with personal hygiene and oral care . b. On 12/07/2020 at 1:47 P.M., Resident #15 was sitting on the bed. Her fingernails on the right hand were uneven in length with jagged edges extending approximately 1/8 of an inch past the nail bed. There was a brown substance under the nails. (Photo taken.) c. On 12/08/2020 at 7:41 A.M., Resident #15 was sitting up on the side of the bed eating cereal. The nails on her right hand were uneven in length with jagged edges. There was a brown substance under the nails and a brown substance around the cuticle of the thumb nail. (Photo taken.) d. On 12/10/2020 at 8:45 A.M., the Director of Nursing (DON) was asked, How often should nail care be done? The DON stated, The Certified Nurse's Aides (CNA's) usually check once a week while giving the showers. Some residents are reluctant to allow their nails to be done. The DON was asked, How much assistance with Activities of Daily Living (ADL's) does (Resident #15) require? The DON stated, She requires one person assistance. When they take her food to her, staff show her where the food is located. The DON was shown a photograph of Resident #15's nails and was asked, Should these nails have been cleaned? The DON stated, Yes. We used to utilize her daughter to do her nails because she was reluctant to allow staff to do them. The DON was asked, Is there a build-up of a dark substance by the resident's cuticles on the residents' hands? The DON stated, Yes. She uses her hands to eat. The DON was asked, Should staff have washed the resident's hand before she started eating her breakfast? The DON stated, Yes, they have wipes they can assist residents to use to clean their hands. (continued on next page)

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

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	e. On 12/10/2020 at 9:25 A.M., Certified Nursing Assistant (CNA) #4 was asked, Do you provide care to (Resident #15)? CNA #4 stated, Yes. CNA #4 was asked, How much assistance with Activities of Daily Living does (Resident #15) require? CNA #4 stated, She requires moderate assistance with toileting. Here lately she has been almost total care with everything. CNA #4 was asked, How often should nail care be performed? CNA #4 stated, Nail care is done on the residents shower days. That is usually twice a week. CNA #4 was asked, When are (Resident #15's) shower days? CNA #4 stated. Yesterday she had a shower. I would have to look to see what other day she has a shower. CNA #4 was shown a photograph of Resident #15's nails and asked, Should the residents nails have been cleaned before she ate? CNA #4 stated, Yes. CNA #4 was asked, Does (Resident #15) refuse ADL care? CNA #4 stated, Sometimes she does. She is afraid of the shower at times, so we give her a bed bath and try to wash her nails. CNA #4 was asked, Did the aide that did (Resident #15's) shower yesterday clean her nails? CNA #4 stated, Yes, the shower aide soaked her nails for a long time yesterday. She sometimes gets build up around her nails that is hard to get off and there was still some build up left even after she soaked the nails. f. On 12/10/2020 at 9:45 A.M., Registered Nurse (RN) #1 was asked, How much assistance with activities of daily living does (Resident #15) require? RN #1 stated, She is total assistance with transfers, and dressing. She feeds herself after we set up the tray. RN # 1 was asked, How often is nail care performed? RN #1 stated, Nail care is done with the residents showers and any time that you see that it needs to be done. RN #1 was asked, Who is responsible for performing nail care? RN #1 stated, The shower team on shower days. The nurses or the aides if they see that they need to be done. RN #1 was shown a photograph of (Resident #15's) nails and was asked, Should the residents' hands have been washed and nails cleaned before the resident ate? RN #1 stated, Yes they should. RN #1 was asked, Has it ever been reported to you that (Resident #15) has refused ADL care? RN #1 stated, It has never been reported to me that she refuses care. RN #1 was asked, How do the CNA's know when a residents shower day is scheduled? RN #1 stated, There is a list in the shower room of the resident's shower days, and it is updated often. RN #1 was asked, What days does (Resident #15) get a shower? After looking at the shower schedule RN #1 stated, She gets a shower on Saturday and Wednesday. g. A Care of Fingernail/Toenails policy provided by the DON on 12/10/2020 at 11:30 A.M. documented, Purpose: The purposes of this procedure are to clean the nail bed, to keep the nails trimmed, and to prevent infection. Nail care includes daily cleaning and regular trimming .

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation of the medication passes on 12/09/2020, record review, and interview of the medication passes on 12/09/2020 at 8:00 A.M., 12:00 P.M., and 1:00 P.M. the facility failed to ensure physician's orders were followed to maintain a medication error rate was less than 5% to prevent potential complications for 2 residents (Residents #30, and #5) of 5 residents observed during the medication passes resulting in medication errors. The medication errors were made by Registered Nurse (RN #1) who administered medications in the facility. The medication error rate was 8.0% (percent) based on 25 medications administered with 2 errors detected. This failed practice had the potential to affect 15 residents who received medications from RN #1 according to a list provided by the Administrator on 12/29/2020. The findings are: 1. Resident #30 had a [DIAGNOSES REDACTED]. a. The December 2020 Physician Orders documented, . Zinc tablet Give 200mg by mouth every day shift for vitamin deficiency . Order Date 12/06/2020. b. On 12/09/2020 at 7:25 A.M., RN #1 administered Zinc Sulfate tablet 220mg by mouth to Resident #30. 2. Resident #5 had a [DIAGNOSES REDACTED]. a. The December 2020 Physician Orders documented, . Zinc tablet Give 200mg by mouth every day shift for vitamin deficiency . Order Date 12/06/2020. b. On 12/9/2020 at 7:45 A.M., RN #1 administered Zinc Sulfate tablet 220mg by mouth to Resident #5. 3. On 12/09/2020 at 9:00 A.M., RN # 1 was asked, Why did you give (Resident #5) and (Resident #30) 220 mg of Zinc Oxide when the dose ordered by the doctor is 200mg? RN #1 stated, It's a stock medication and I think 220mg of Zinc is all we can get. 4. On 12/9/2020 at 9:20 A.M., the DON was asked, Should the nurse have given (Resident #5) and (Resident #30) 220mg of Zinc Oxide when the physicians order documented to give 200mg? The DON stated, The doctor gave the order for what we have in house. We have clarified the order with the physician, and we are changing the order to match the current supply. The DON was asked, Should the nurse have clarified the order before giving the medication? The DON stated, Yes. They should have read the MAR (Medication Administration Record) and clarified the order with the physician at that point. 5. An Administrating Medications policy provided by the DON on 12/09/2020 at 10:30 A.M., documented, . Medications shall be administered in a safe and timely manner, and as prescribed. Policy Interpretation and Implementation . 3. Medications must be administered in accordance with the orders . 7. The individual administering the medication must check the label THREE (3) times to verify the right resident, right medication, right dosage, right time and right method (route) of administration before giving the medication.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview the facility failed to ensure a medication cart left on the quarantine COVID unit was locked and secured. This failed practice had the potential to affect 1 (Resident #23) resident who was ambulatory. The findings are: 1. On 12/07/2020 at 3:50 P.M., there was a medication cart sitting in Resident room [ROOM NUMBER] on the quarantine unit. The medication cart was unlocked. The cart had over the counter and resident medications in it. Certified Nursing Assistant #3 was asked to call the Director of Nursing (DON) to come to the unit. Certified Nursing Assistant #3 was asked, Is there any resident that walks here in the unit? She stated, Yes, just one. The DON was asked, Should this medication cart be unlocked? She stated, No. The nurse from day shift forgot to lock it I guess. A list of all medication that were currently in the cart was requested. 2. On 12/08/2020 at 12:10 P.M., the list of Over the Counter and resident medications in the medication cart were as follows: a. Over the Counter Medications were: [MEDICATION NAME] 20mg (milligrams), Clear Lax, Zinc Sulfate 220mg, Vitamin C 500mg, [MEDICATION NAME] 10mg, [MEDICATION NAME] 100mg, Vitamin B 12 1000mcg (micrograms), Vitamin D 3 125 mcg 5000 IU (international units), CertaVit Senior, Aspirin 325mg, Rena-Vit, Decub-Vit , AZO Cranberry. b. Resident #24's medications: [REDACTED]. c. Resident #23's medications: [REDACTED].M. ointment. d. Resident #211's medications: [REDACTED]. e. Resident #41's medications: [REDACTED]. 3. On 12/09/2020 at 11:20 A.M., the Director of Nursing was asked, Should a medication cart be left unattended and unlocked? She stated, No

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observation and interview the facility failed to properly prevent or contain the spread of COVID-19 by failing to use proper Personal Protective Equipment (PPE) when transferring residents who have been exposed to COVID positive residents; properly disinfecting a room of a COVID positive resident; failed to change dirty gloves and or hand wash/sanitize to prevent cross contamination from dirty to clean, and failed to store biohazard properly to prevent cross contamination. These failed practices had the potential to affect all 39 residents residing in the facility. The findings are: 1. On 12/08/2020 at 12:20 P.M., upon entering the Quarantine Unit Certified Nursing Assistant (CNA) #1 was asked, Where are isolation gowns kept? The isolation cart was empty. CNA #1 went to the dining room to retrieve a gown. The Isolation Cart was approximately 12 foot inside the back door of the unit. CNA #1 and #2 were moving residents on the quarantine hallway. Both of the CNA's had on mask and goggles. They were not wearing a gown or gloves. CNA #2 entered Resident room [ROOM NUMBER] and pulled out a resident's over bed table and nightstand. CNA #2 took the furniture down the hall to Resident room [ROOM NUMBER]. CNA #1 was in the hall and was asked, When are you supposed to wear gowns? She stated, Any time you come into contact with the resident or their belongings. These resident have been exposed. a. On 12/08/2020 at 12:23 P.M., CNA #2 came back up the hallway with the bedside table and nightstand. CNA #1 was putting on gown to move the resident to Resident room [ROOM NUMBER]. CNA #2 came back up the hallway. She did not have on a gown or gloves. She pushed the resident from the room in his wheelchair to Resident room [ROOM NUMBER]. She then went to Resident room [ROOM NUMBER] and started gathering the resident's belongings. CNA#2 did not have on a gown and gloves. b. On 12/09/2020 at 8:32 A.M., the Director of Nursing (DON) was asked, When residents are being moved to the quarantine unit, or being moved in the quarantine unit what is the protocol for wearing personal protective equipment (PPE)? She stated, The staff is to wear gown, gloves, mask and googles. 2. On 12/09/2020 at 9:28 A.M., Licensed Practical Nurse (LPN) #1 with gloved hands opened the top drawer of the medication cart. LPN #1 pulled out a box with an inhaler in it. He then reached back in the drawer to get another box. LPN #1 already had a medication cup with meds on the top of the cart. LPN #1 then poured a cup of water and walked over to the resident sitting in the doorway of Resident room [ROOM NUMBER] and handed the medication cup to the resident. He then handed her the water glass which she drank all of. LPN #1 took the cup from the resident, went back to the cart with the same gloved hands, and poured more water into the cup. LPN #1 went back to the resident and handed her the cup of water. LPN #1 then went back to the cart and proceeded to box up inhalers placing them back in the medication cart with the same gloved hand. He put all of the medication cards back into the medication cart without changing gloves. The Nurse then took off his gloves and sanitized his hands. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	a. On 12/09/2020 at 10:00 A.M., the Director of Nursing (DON) was asked, During medication pass on the quarantine unit, how do expect your staff to perform a medication pass? She stated, I expect them to use infection control policy. The DON was asked, The nurse was observed to pass medication to a resident with gloves on and during the medication pass he went back to get more water. (LPN #1) went back to the cart got more water and handed the cup back to the resident with the same gloves. Is this proper protocol? She stated, No. The DON was asked, (LPN #1) went back to the cart and continued to put back medication in the cart without changing gloves. How could this impact the rest of the residents? She stated, Infection Control. b. An Administering Medication Policy and Procedure provided by the DON on 12/09/2020 at 10:30 A.M. documented, . staff shall follow established facility infection control procedures COVID-19 Risk Mitigation plan states . while in contact with PUI or isolation room, limit opportunities for touch contamination . 3. On 12/09/2020 at 9:34 A.M., the biohazard room on the front of 200 hall had 6 biohazard boxes on the floor. The top two biohazard boxes were open. On 12/09/2020 at 9:45 A.M., the Maintenance Director was asked, How should biohazard be stored in the biohazard room? He stated, It should be stored in the boxes. He was asked, Should the boxes be open? He stated, No, not at all. They should be closed. He was asked, Should they be stored on the floor? He stated, No. He was asked, How often is the biohazard boxes picked up from facility? He stated, On Monday and Thursday. He was asked, Have you had any trouble getting biohazard picked up in the last four weeks? He stated, No. 4. On 12/09/2020 at 10:38 A.M., the Maintenance Director was asked, This morning you used a UV (ultraviolet light) on room [ROOM NUMBER]? He stated, Yes. He was asked, Did you wear PPE when you went in the room? He stated, Yes. He was asked, Who cleans the room? He stated, Housekeeping. On 12/09/2020 at 11:30 A.M., Housekeeper #1 was in Resident room [ROOM NUMBER] and had on gloves, mask and goggles. She did not have on a gown. The room was wiped down with Virex. The curtains were taken down and all surfaces cleaned. Housekeeper #1 was asked, Did you disinfect the trash cans? She stated, Yes. Housekeeper #1 was asked, Did you disinfect the windowsills and walls? She stated, Yes. She was asked, What did you do with the cloth rags that you cleaned the room with? She stated, I put them in a trash bag. She was asked, Did you wear a gown while cleaning the room? She stated, No. She was asked, Have you been in-serviced on how to clean a COVID positive room? She stated, Yes. She was asked, Were you told the room you just cleaned was a COVID positive room? She stated, No (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 12/09/2020 at 11:40 A.M., the District Manager of Healthcare Services Group and the Regional Consultant was asked, Has Housekeeper #1 been in-serviced on how to clean a COVID positive resident room? The District Manager stated, Yes. The District Manager and the Regional Consultant was asked, According to your policy on page 4 the recommendation is to wear a disposable gown. Housekeeper #1 just cleaned Resident room [ROOM NUMBER] without a gown. Should she have been in full PPE since the resident was COVID positive? The District Manager and the Regional Consultant both said Yes. The District Manager and the Regional Consultant was asked, Your policy also states that .linens, rags, mop heads. Use the double bag method . Should the housekeeper have double bagged what came out of that room? The Regional Consultant and the District Manager both stated, Yes. The District Manager and the Regional Consultant was asked, The policy also states that a sign will be placed on the door to inform people that there was a COVID positive resident in that room. Should you have put a sign up? They stated, Yes. The District Manager and the Regional Consultant was asked, Do you believe the housekeeper could have done her job correctly if she had been given all the information she needed? They both stated, Yes.