STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045167	A. Building B. Wing	10/09/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Springdale Health and Rehabilitation Center	102 North Gutensohn Springdale, AR 72762

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Complaint # (AR 545) and Complaint # (AR 608) was substantiated, all or in part, with these findings: Based on observation and interview the facility failed to ensure the floors were clean and free of debris, bed linen was clean and free of stains, trash was emptied, bedside tables were clean, a mechanical lift was clean, toilets were flushed and clean, and a bathroom was free of odors to promote a clean and sanitary environment for 3 (Resident #1, 2, and 3) of 7 (Resident 1-7) case mix residents who resided in the facility. This failed practice had the potential to affect all 99 residents, according to the Midnight Census Report dated 10/6/2020. The findings are: 1. Resident #1 had [DIAGNOSES REDACTED]. The Quarterly Minimum Data Set with an Assessment Reference Date of 9/22/2020 documented the resident scored 10 (8-12 indicates moderately impaired) on a Brief Interview for Mental Status (BIMS); and required 2 person assist with transfers and toileting needs. a. On 10/6/2020 at 5:10 a.m., Resident #1 was lying on his right side in bed. Resident #1 had feces on his bed linens. b. On 10/6/2020 at 4:30 p.m., Certified Nursing Assistant (CNA) #1 was asked, Why did (Resident #1) have feces on his socks and bed linens? CNA #1 stated, He will take himself to the bathroom. He has been having loose stools. 2. Resident #2 had [DIAGNOSES REDACTED]. The Annual Minimum Data Set with an Assessment Reference Date of 9/7/2020 documented the resident scored 13 (13-15 indicates cognitively intact) on a Brief Interview for Mental Status; and required 2 person assist with transfers and toileting needs. a. On 10/6/2020 at 5:15 a.m., Resident #2 was in his wheelchair inside the doorway of his room. The floor in his room had scattered debris. The debris consisted of popcorn, napkins, plastic wrappers, and debris of unknown origins. The resident's bedside table had a sticky substance visible on the top surface of the table and there was a cockroach under the resident's bed. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. On 10/6/2020 at 5:23 a.m., in Resident room [ROOM NUMBER] Bed A on the A Hall the resident's bed was full of debris of unknown origins. There were small black particles scattered all over the resident's bed linens. The linens were stained a brown color in several areas proximal to the resident's feet and posterior region. a. On 10/6/2020 at 5:25 a.m., Registered Nurse (RN) #1 was asked, Why is this resident's bed linens so dirty and why are these stained towels wrapped on his feet? RN #1 stated, He doesn't like to change his clothes and a lot of times he will refuse care. I don't know why those towels are wrapped around his feet. I do know he has some mental health issues. 4. Resident #3 had [DIAGNOSES REDACTED]. The Quarterly Minimum Data Set with an Assessment Reference Date of 7/24/2020 documented the resident was unable to complete a Staff Interview for Mental Status because rarely or never understood. The resident required one person assist with transfers and toileting needs. a. On 10/6/2020 at 5:34 a.m., Resident #3 was in the bathroom with a CNA assisting her with the door closed. There was a dead cockroach on the resident's bed linen that was immediately removed from the bed by RN #1. 5. On 10/6/2020 at 5:38 a.m., in Resident room [ROOM NUMBER] A there was scattered debris on the floor. There were food crumbs and miscellaneous items of unknown origins. The floor had a sticky substance that had encrusted shoe prints visible from the hallway. 6. On 10/6/2020 at 5:48 a.m., in Resident room [ROOM NUMBER] there was food crumbs and miscellaneous debris, including tissues and plastic wrappings, scattered all over the floor. The bedside table had food crumbs on the top surface of the table. 7. On 10/6/2020 at 5:55 a.m., in Resident room [ROOM NUMBER] there was a plastic trash container stuffed with used briefs and/or undergarments. The plastic trash container in the bathroom was stuffed with used briefs and/or undergarments. On the floor in the bathroom was a dried yellow substance. 8. On 10/6/2020 at 5:58 a.m., the mechanical lift in the hallway had dried on dust and debris particles all over it. There were food particles, wrappings, and an unknown dark substance on the leg extensions and lower mechanisms of the mechanical lift. 9. On 10/6/2020 at 6:00 a.m., in Resident room [ROOM NUMBER] the toilet in the bathroom had stool and feces in the toilet bowel and on the toilet seat and outer surfaces of the commode. The plastic trash container, in the bathroom was stuffed full of used undergarments and briefs. The room smelled of urine and stool.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** Complaint # (AR 545) was substantiated, all or in part, with a deficiency cited at F677. Based on observation and interview the facility failed to ensure residents hair and socks were clean, and clean linen was provided to maintain good hygiene and grooming for 2 (Resident #1 and 2) of 2 case mix residents who require assistance with Activities of Daily Living (ADLs). This failed practice had the potential to affect all 99 residents, according to the Midnight Census Report dated 10/6/2020. The findings are: 1. On 10/6/2020 at 5:10 a.m., Resident #1 was lying on his right side in bed. Resident #1 had feces on his socks. a. On 10/6/2020 at 4:30 p.m., Certified Nursing Assistant (CNA) #1 was asked, Why did (Resident #1) have feces on his socks? CNA #1 stated, He will take himself to the bathroom. He has been having loose stools. 2. Resident #2 had [DIAGNOSES REDACTED]. The Annual Minimum Data Set with an Assessment Reference Date of 9/7/2020 documented the resident scored 13 (13-15 indicates cognitively intact) on a Brief Interview for Mental Status; and required 2 person assist with transfers and toileting needs. a. On 10/6/2020 at 5:15 a.m., Resident #2 was in his wheelchair inside the doorway of his room. His hair was unkept and his scalp was flaky. His left eye was reddened.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observation and interview, the facility failed to ensure a multipurpose cleaner was properly stored as evidence by the cleaner being in the hallway in reach of residents. This failed practice had the potential to affect 99 residents who reside in the facility according to the Census. The findings are: 1. On 10/6/2020 at 5:18 a.m., a bottle of Diffense Multi-Purpose Cleaner Disinfectant was sitting on the handrails on the E Hall. A total of seventeen residents resided on E Hall. a. On 10/6/2020 at 5:20 a.m., Registered Nurse (RN #1) was asked, Is this Multi-Purpose Disinfectant supposed to be stored in the hallway? RN #1 stated, No. It should be locked up in the Storage Room.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the facility failed to ensure oxygen tubing was changed out per Physician's Orders and per Standard of Practice to prevent the increased risk of respiratory infections for 2 (Residents #4 and #5) who had orders for as needed oxygen and were currently using daily due to Covid-19 respiratory symptoms. The findings are: 1. Resident #4 had [DIAGNOSES REDACTED]. The Annual Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 8/13/2020 documented the resident scored 15 (13-15 indicates cognitively intact) on a Brief Interview for Mental Status (BIMS); and required 2 person assist with transfers and toileting needs. a. A Physician's Orders dated 2/3/2020 documented, .Oxygen 2 l (liters) via (by way of) nasal cannula as needed .Dx (diagnosis): SOB (shortness of breath) .Change 02 (oxygen) tubing, humidifier, storage bag and rinse filter Q (every) Sunday 11-7 shift . b. On 10/6/2020 at 5:55 a.m., Resident #4 was in bed with her eyes closed. The resident was not receiving oxygen. The humidifier on the oxygen concentrator was dated 9/21/2020. The oxygen tubing was not dated and there was no storage bag present. c. On 10/7/2020 at 10:06 a.m., Licensed Practical Nurse (LPN #1) was asked, When should the oxygen tubing and humidifier be replaced? LPN #1 stated, It should be changed out every week. LPN #1 was asked, Who is responsible for changing out the tubing and humidifiers? LPN #1 stated, It is the night shift nurse's responsibility on Sunday to change out the tubing and humidifiers. LPN #1 was asked, Why hasn't (Resident #4) humidifier and tubing been replaced weekly? LPN #1 stated, Different staff trying to pull different shifts. It used to be assigned to certain staff. Usually on the night shift. It just has kind of gotten crazy around here. 2. Resident #5 had [DIAGNOSES REDACTED]. The Quarterly Minimum Data Set with an Assessment Reference Date of 9/11/2020 documented the resident was unable to complete a Staff Interview for Mental Status because of short term memory deficits. The resident required 1 person assist with transfers and toileting needs. a. A physician order dated 9/29/2020 documented, .Oxygen 2 l (liters) via nasal cannula as needed .Dx (diagnosis): SOB (shortness of breath) .Change 02 (oxygen) tubing, humidifier, storage bag and rinse filter Q (every) Sunday 11-7 shift . b. On 10/6/2020 at 5:50 a.m., Resident #5 was in bed with her eyes closed. The resident was not receiving oxygen. The oxygen tubing was dated 9/25/2020. A storage bag and humidifier were present. c. On 10/6/2020 at 5:56 a.m., Registered Nurse (RN #1) was asked, When should a resident's oxygen tubing and humidifier be replaced? RN #1 stated, It should be changed out once a week. The night shift nurse on Sunday is responsible for changing out oxygen tubing on their assigned halls.

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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** Complaint # (AR 621) was substantiated, all or in part, with these findings: Based on observation and interview, the facility failed to ensure staff members were following facility policies and Centers for Disease Control and Prevention (CDC) guidelines regarding the wearing of a N95 or equivalent mask on the Covid-19 positive unit to decrease the risk of transmission of Covid-19 on 1 of 1 Covid-19 Unit. The facility failed to ensure bio-hazard contents and soiled linens were properly stored to prevent the increased risk of transmission of infectious pathogens for residents who resided on a designated Covid-19 unit. These failed practices had the potential to affect all 19 residents who resided on the F Hall and were already immunocompromised related to testing positive for Covid-19. The facility also failed to ensure 2 blood saturated dressings were properly discarded in a biohazardous waste container to prevent the increased risk of bloodborne pathogens. These failed practices had the potential to affect all 99 residents, according to the Midnight Census dated 10/6/2020. 1. On 10/6/2020 at 5:50 a.m., Certified Nursing Assistant (CNA #2) was observed on F Hall. F Hall was a designated Covid-19 positive unit. Nineteen residents resided on F Hall. CNA #2 was wearing only a surgical mask. a. On 10/6/2020 at 6:00 a.m., CNA #2 was asked, Why are you not wearing a N95 mask or equivalent mask on a Covid-19 positive unit? CNA #2 stated, I just forgot. I had one on earlier. b. On 10/7/2020 at 9:11 a.m., the Director of Nurses (DON) was asked, What is your policy on wearing N95 or equivalent mask on the Covid-19 positive units? The DON stated, The staff know that they are supposed to wear a N95 mask on the Covid units. We have both N95 masks and K95 masks. 2. On 10/6/2020 at 5:38 a.m., the F Hall was observed with RN #1 present. In the hallway were six to seven red bio-hazard bags stacked on a rolling dolly. A bio-hazard bag was observed on the floor on F Hall. The red bio-hazard bags were sealed or tied in a knot. A yellow, 'Soiled Linen' plastic, industrial container was observed in the hallway. The lid was off the container. The yellow container had two to three stuffed, tied bags of soiled linens inside and one protruding above the container. Two stuffed, dirty linen bags were observed on the floor in the hallway. On 10/7/2020 at 10:20 a.m., the Administrator was asked, Why were all those bio-hazard bags and soiled linen bags in the hallway? The Administrator stated, I couldn't tell you. The bio-hazard is picked up two times a week on Tuesday and Thursday. They picked up the biohazards yesterday. It should of been taken out to our storage shed where we put all the bio-hazards. The linens should have been taken to laundry. 3. On 10/6/2020 at 4:53 a.m., in Resident room [ROOM NUMBER] on D Hall, on the chair were two blood saturated dressings. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/6/2020 at 4:55 a.m., RN #1 was asked, Why are those bloody dressings on the chair in room [ROOM NUMBER]? RN #1 stated, The resident probably took them off and put them there. I will make sure they get disposed of properly.