Printed: 07/30/2025
Form Approved OMB
No. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 045125 | A. Building<br>B. Wing | 03/06/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Butterfield Trail Village | 1923 East Joyce Blvd<br>Fayetteville, AR 72703 |

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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information) |
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| F 0602<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Protect each resident from the wrongful use of the resident's belongings or money.<br><br>50924<br><br>Based on observations, interviews, record review, facility document review, and facility policy review, it was determined that the facility failed to maintain the manufacturer's integrity of a sealed controlled medication prescribed for a resident and securely stored by the facility for 1 (Resident #1) of 7 Residents reviewed for personal property, specifically a sealed bottle of liquid opioid pain medication recorded and stored by staff nurses, was opened and missing part of its contents without the request of, or assessed need for, the prescribed resident.<br><br>The findings include:<br><br>A review of a facility policy titled, Storage of Medications, revised April 2007, indicated, Drugs and biologicals shall be stored in the packaging, containers or other dispensing systems in which they are received. Compartments (including, but not limited to, drawers, cabinets, rooms, refrigerators, carts, and boxes.) containing drugs and biologicals shall be locked when not in use, and trays or carts used to transport such items shall not be left unattended if open or otherwise potentially available to others. Only persons authorized to prepare and administer medications shall have access to the medication room, including keys.<br><br>A review of a facility undated policy titled, Abuse and Neglect-Clinical Protocol failed to define and address Misappropriation of Property as abuse.<br><br>A review of an in-service titled, Abuse & Neglect, With Emphasis on Misappropriation of Resident Property, Presented on 11/25/2024, by the Administrator was signed by 89 staff members for educational purposes. A handwritten note stated Handout Attached, Emphasis on Resident property! *Misappropriation of Resident Property i.e.Medications. A sticky note attached to the page stated Reportable [Resident Name (Resident #1)] 11/25/2024. The handout attached was the facility policies titled, Abuse and Neglect-Clinical Protocol and Abuse Investigating and Reporting.<br><br>(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 0602<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | A review of the OLTC Incident and Accident Report submitted on 11/25/2024, indicated at approximately 5:24 AM on 11/25/2024, LPN #1 notified the Director of Nursing (DON) about a liquid narcotic belonging to Resident #1 which had been found with the seal off the bottle like it had been used. The DON investigated and discovered the syringe had been used by observing a blue-like substance inside the syringe itself. The DON reviewed the narcotic medication sign out book and Resident #1's MAR [medication administration record] and found no documented doses had been signed out or administered. The medication was received by the facility from the pharmacy on 08/20/2024, according to hospice orders. LPN #4 remembered the (Brand Name) opioid medication sealed and unused 4 days prior and when she returned to work it had been opened and perhaps used.<br><br>A review of an in-service titled, Nurses: Narcotic Counts/ Including Liquids, presented by the Administrator on 11/25/2024, signed by 19 nurses indicated, nurses should remove the liquid narcotics from the box and visually look at the level and document accordingly. If there is a discrepancy you must notify the DON immediately. Also, check the narcotic box during your shift to ensure each bottle of liquid is in an upright position to prevent any possible leakage.<br><br>A review of an email from the Retail Pharmacist sent 11/26/2024, indicated, It is a common problem that we get reported from multiple facilities that the [Brand Name] bottle end up short by the bottles end, despite diligent efforts to measure accurately by staff. It is my opinion that some of this might be due to the viscosity of the liquid adhering to the plastic at the end [you can never get 100% of the liquid out of the bottle]. Make sure the staff continues only using the calibrated syringe provided by the manufacturer. We will continue sending [Name brand] opioid medication bottles in their sealed containers only due to this common problem to reduce the uncertainty of what is inside the bottle. If hospice allows, we will aim to provide 15ml [milliliter] bottles rather than 30ml to reduce waste and hopefully cut down on the discrepancy at the end. No indication of any issues with the seals coming off or leakage from storage was noted by the pharmacist.<br><br>A review of the Resident Summary, indicated the facility admitted Resident #1 in 2018, with diagnoses which included muscle weakness, fall, knee pain, hip pain, cervical spine ligaments sprain, tendon of the lower back strain, primary generalized arthritis, age-related physical debility, age-related osteoporosis, mild cognitive impairment, and dysphagia.<br><br>The quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 02/06/2025, revealed Resident #1 had a Staff Assessment of Mental Status (SAMS) score of 2 which indicated the resident had moderate cognitive impairment. Assessment of pain indicated, Resident #1 received a scheduled pain medication regimen and had a condition or chronic disease that may result in a life expectancy of less than 6 months.<br><br>A review of Resident #1's Care Plan, undated, revealed Resident #1 had an altered comfort level/pain related to osteoarthritis and mobility and potential for edema, chest pain, shortness of breath, and elevated blood pressure. Interventions included, administer medications per physicians orders.<br><br>A review of Resident #1 ' s Physician Orders revealed order to Admit to (Specific Business Name) Hospice Services, dated 08/20/2024.<br><br>A review of Physician Orders, revealed, (Brand Name) concentration oral solution, the opioid medication was ordered on 08/20/2024 for pain or shortness of breath. The dose was 0.25 milliliters (ml), or 5 milligrams (mg) as needed every 30 minutes.<br><br>(continued on next page) |

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| F 0602<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | A review of the controlled medication book, page 45, revealed, Resident #1's (Brand Name) liquid opioid medication with prescription number 44496, dispensed by (Retail Pharmacy), was entered into the log on 08/20/2024, with an illegible nurse's signature. No doses were ever signed out.<br><br>A review of the monthly MAR [Medication Administration Record], from 8/2024-11/2024, revealed Resident #1 had zero doses of the (Brand Name) liquid opioid medications administered.<br><br>During an interview on 03/04/2025 at 1:00 PM, Licensed Practical Nurse (LPN) #1 stated, she found Resident #1's (Brand Name) liquid opioid medication without the seal on it and the syringe containing a blue liquid on the inside of the syringe. The medication was the same color as the blue liquid on the inside of the syringe. LPN #1 did not remember if the seal was still in the box or was completely gone. She stated the syringe, and the medication bottle were both stored in the original box prior to use and after use the staff kept the syringe in a plastic bag, so it did not get liquid on everything. LPN #1 stated, after the incident with Resident #1's medication the staff were told to store the liquid bottles of [Name Brand] opioid medication standing up right to prevent leakage. LPN #1 stated, she wanted to trust her coworkers and believed someone may have pulled (Brand Name) liquid opioid medication from the wrong bottle, without telling anyone. LPN #1 stated why else would the (Brand Name) opioid medication be on the inside of the syringe.<br><br>During an interview on 03/04/2025 at 3:20 PM, LPN #2 stated, she and LPN #1 noticed the seal was off Resident #1's (Brand Name) opioid medication bottle and open, but there were no doses administered according to the narcotic sign out book. LPN #2 did not remember anything about the syringe in the box but stated the seal was not in the box or the drawer of the cart and could not be located. The Director of Nursing (DON) was notified, and the facility sent everyone for drug testing. LPN #2 stated we had a couple of sketchy nurses' I think it was intentional. LPN #2 also stated while LPN #1 was at lunch, she would have possession of LPN #1 ' s medication cart keys.<br><br>During an interview on 03/05/2025 at 10:20 AM, the DON stated that no seal was found with the bottle of (Brand Name) opioid medication for Resident #1. Blue liquid matching the (Brand Name) opioid medication was found on the inside of the syringe. The DON stated she was unable to identify who opened the seal and what happened to the missing (Brand Name) opioid medication. 3ml or 60 milligrams (mg) of (Brand Name) opioid medication was missing. It was the only bottle of (Brand Name) opioid medication on the medication cart at the time.<br><br>During an interview on 03/06/2025 at 12:23 PM, the Retail Pharmacist stated, he was not aware of any leakage issues with this specific manufacturer's bottle or any issues with seals coming off. He had heard from facilities an issue with the viscosity (thickness) of the liquid. It sticks to the bottle, and you can never get everything out of the bottle. The (Brand Name) opioid medication bottle comes packaged in a box with the manufacturer's sealed bottle and a plastic wrapped syringe and stopper. It is the facilities responsibility to break the seal with the stopper. The retail pharmacy opens the boxes before they are distributed to the facility and checks them. There is not going to be a syringe not in a plastic wrapper with any in it going out. If there is an issue with the syringe out of the wrapper and liquid in the syringe that happened at the facility.<br><br>During an observation on 03/05/2025 at 10:25 PM, the DON provided 2 pictures of the syringe taken during her investigation. The light blue liquid with thick viscosity as the pharmacist described can be seen stuck to the inside of the syringe and on the stopper.<br><br>(continued on next page) |

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| F 0602<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview on 03/06/2025 at 3:00 PM, the DON stated, I could come to any conclusion as to where the (Brand Name) opioid medication went. I think somebody took it because the syringe had dry blue residue inside the syringe. So, yes, the property was taken from the resident.<br><br>During an interview on 03/06/2025 at 3:10 PM, the Administrator stated, We sent nurses for drug tests, every nurse for a 2-week period and all the tests were negative. The nurses stated they had no knowledge of what happened to the (Brand Name) opioid medication. We sent the bottle for destruction and purchased a new bottle for Resident #1. I do not know if it was taken by somebody and stolen from the resident. I do not know how the seal got broken. We did not have any agency nurses in the facility, and I don't believe there was any nurse who quit, and we didn't do drug tests. We checked everyone who the DON identified as having access. We did not have a sign out for lunch as to who was covering for who at lunch. The Administrator was not aware nurses handed off keys when another nurse covered for them at lunch.<br><br>During an interview on 03/06/2025 at 3:28 PM, the DON stated that We only drug tested nurses who signed out medication on the residents' MAR for that medication cart for 2 weeks. I did not look at those who might have been covering for another nurse at lunch and were in possession of those keys. |

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F 0726

Level of Harm - Actual harm

Residents Affected - Some

Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being.

**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50924

Based on observations, interviews, record review, facility document review, and facility policy review, it was determined that the facility failed to identify, assess, and evaluate the nursing staff's knowledge, skill level, and ability to provide emergent care in life threating situations or maintain and utilize available emergency medical equipment when reviewed for competently skilled nursing services.

The findings include:

A review of the facility's Facility Assessment updated [DATE] and last reviewed with the QAA (Quality Assessment & Assurance)/QAPI (Quality Assurance & Performance Improvement) committee [DATE], revealed, the persons identified in completing the assessment were the Senior Director of Healthcare Services, the Administrator, the Director of Nursing, and the Medical Director. Part 1: Our Resident Profile- The intent was to identify common diagnoses in the resident population in order to identify the types of human and material resources necessary to meet the needs of the resident's living with these conditions or a combination of these conditions. Heart/Circulatory System identified diagnoses included Congestive Heart Failure (CHF) and hypertension. Respiratory identified diagnosis included Chronic Obstructive Pulmonary Disease (COPD) and respiratory failure. Part 2: Services and Care We Offer Based on Our Residents' Needs- Assessment, early identification of problems/deterioration, management of medical symptoms and conditions of heart failure and chronic obstructive pulmonary disease (COPD). Part 3: Facility Resources Needed to Provide Competent Support and Care for Our Resident Population Every Day and During Emergencies- Identify the type of staff members, other health care professionals, and medical practitioners that are needed to provide support and care for residents. Potential data sources include staffing records and organization charts. Staffing Plan: Evaluation of the overall number of facility staff needed to ensure a sufficient number of qualified staff is available to meet each resident's needs. Evaluation of residents' needs and overall acuity levels revealed the total number of staff needed were ,d+[DATE] licensed nurses providing care and ,d+[DATE] nurses' aides depending on the shift. Individual staff assignment: Staffing strategically planned based on acuity levels on halls. Staff training/education and competencies: Licensed, CPR is done annually or when expired. All onboarding employees receive orientation and a list to be checked off due within one month of hire. The facility performed skills check offs at least annually and upon I&As (Incidents & Accidents). The nursing department has competency forms filled out and checked upon new hire and annually. No plan to identify or evaluate the competency of staff in medical emergency situations was assessed by the facility.

A review of the facility's Education Calendar 2025 provided by the Administrator on [DATE], revealed no scheduled CPR [Cardiopulmonary Resuscitation] or BLS [Basic Life Support] training, no mock codes, or medical equipment training.

A review of the facility's Nurse Skills Checklist, LPN [Licensed Practical Nurse] or RN [Registered Nurse] revised [DATE], revealed no section for medical emergencies, no section for emergency medical equipment, and no section to indicate CPR/BLS certification.

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| F 0726<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Some | A review of the facility's 2024 Skills and Competency Fair sheet for nurses' and CNAs [Certified Nursing Assistants] revealed no competency check off was indicated for medical emergency equipment or required certifications.<br><br>A review of a facility policy titled, Advanced Directives, revised [DATE], indicated, Advanced Directives will be respected in accordance with state law and facility policy.<br><br>A review of a facility policy titled, Emergency Procedures-Cardiopulmonary Resuscitation, revised February 2018, indicated, Personnel have completed training on the initiation of cardiopulmonary resuscitation (CPR) and basic life support (BLS), including defibrillation, for victims of sudden cardiac arrest. Victims of cardiac arrest may initially have gasping respirations or may appear to be having a seizure. Training in BLS includes recognizing presentation of SCA [Sudden Cardiac Arrest]. The chances of surviving SCA may be increased if CPR is initiated immediately upon collapse. Early delivery of a chock with a defibrillator plus CPR within , d+[DATE] minutes of collapse can further increase chances of survival. If an individual (resident, visitor, or staff member) is found unresponsive and not breathing normally, a licensed staff member who is certified in CPR/BLS shall initiated CPR unless: a. it is known that a Do Not Resuscitate (DNR) order that specifically prohibits CPR and/or external defibrillation exists for that individual; or b. there are obvious signs of irreversible death (e.g., rigor mortis). If the first responder is not CPR-certified, that person will call 911 and follow the 911 operator's instructions until a CPR-certified staff member arrives. Preparation for Cardiopulmonary Resuscitation included, Obtain and/or maintain American red Cross or American Heart Association certification in Basic Life Support (BLS/Cardiopulmonary Resuscitation (CPR) for key clinical staff members who will direct resuscitative efforts, including non-licensed personnel. The facility's procedure for administering CPR shall incorporate the steps covered in the 2010 American Heart Association Guidelines for Cardiopulmonary Resuscitation and Emergency Cardiovascular Care or facility BLS training material. Provide Mock Codes (simulations of an actual cardiac arrest) for training purposes. Select and identify a CPR team for each shift in the case of an actual cardiac arrest. To the extent possible, designate a team leader on each shift who is responsible for coordinating the rescue effort and directing other team members during the rescue effort. The CPR team in this facility shall include at least one nurse, one LPN [Licensed Practical Nurse]/LVN [Licensed Vocational Nurse] and two CNAs [Certified Nursing Assistants], all of whom have received training and certification in CPR/BLS. Maintain equipment and supplies necessary for CPR/BLS in the facility at all times. Provide information on CRP/BLS policies and advance directives to each resident/representative upon admission. Emergency Procedures-Cardiopulmonary Resuscitation included, If an individual is found unresponsive, briefly assess for abnormal or absence of breathing. If sudden cardiac death is likely, begin CPR: a. Instruct a staff member to activate the emergency response system (code) and call 911. b. Instruct a staff member to retrieve the automatic external defibrillator. c. Verify or instruct staff members to verify the DNR or code status of the individual. d. Initiate the basic life support (BLS) sequence of events. Airway: Tilt head back and lift chin to clear airway. When the AED arrives, assess for need and follow AED protocol as indicated. Continue with CPR/BLS until emergency medical personnel arrive.<br><br>A review of an in-service titled, CPR Training, dated [DATE], revealed 9 staff members who attended CPR training, 8 are still active employees, and 7 are bedside staff.<br><br>A review of the Registered Nurse & Licensed Practical Nurse, Job Description, revealed that no CPR certification/training was listed under qualifications.<br><br>(continued on next page) |

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| F 0726<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Some | A review of the list Code Status, provided by the DON [Director of Nursing] on [DATE] at 2:02 PM, revealed 14 of the 50 residents in the facility selected full code meaning the 14 identified residents wished to have CPR for life sustaining intervention if they were to require it.<br><br>A review of the Resident Summary, indicated on [DATE] the facility admitted Resident #4 with diagnoses which included acute on chronic congestive heart failure, acute kidney failure, emphysema, type 2 diabetes, anemia, COPD [chronic obstructive pulmonary disease], hyperlipidemia, hypertension, and atrial fibrillation.<br><br>The admission Minimum Data Set (MDS) was never completed for Resident #4 prior to the resident's death on [DATE].<br><br>A review of Resident #4's Care Plan, dated [DATE], revealed the resident was admitted for continuing care of an unstable condition. Interventions included monitoring respiratory, circulation, and cardiac status: lung sounds, vital signs, oxygenation status, skin color and turgor, nailbed color, activity tolerance. Note presence of lethargy, mottling, confusion, change in mood or demeanor.<br><br>A review of Resident #4's facility Advanced Directive form signed [DATE], by Resident #4's family representative and witnessed by LPN #3 indicated, Resident #4 ' s wish to be a full code by marking the line stating, Yes, I DO WANT the staff to begin CPR and call 911 with the intention of providing resuscitation and other emergent life-saving measures.<br><br>A review of Physician Orders, revealed Resident #4 ' s order stated, DNR Form: no; CPR-CODE entered by LPN #4 on [DATE] at 4:06 PM. An order for Oxygen 3L (Liters) via NC (Nasal Cannula) continuously for SOB (Shortness of Breath)/COPD Exacerbation.<br><br>A review of Resident #4's internal investigation documentation revealed:<br><br>1.The facility submitted a report to the OLTC (Office of Long-Term Care) Incident and Accident Report (I&A) on [DATE] at 8:44 AM, a summary of Incident indicating, Resident #4 reported SOB at 11:40 PM om [DATE]. Resident #4 was addressed by LPN #1 as SOB and using accessory muscles to assist in breathing. LPN #4 exchanged Resident #4's oxygen delivery system from NC to a mask related to the resident's breathing technique. A medicated inhaler was administered at 11:50 PM per LPN #1 without relieving the SOB. LPN #1 left the resident and phoned the on-call provider. While LPN #1 was on the phone a CNA reported Resident #4 was found on the floor and bleeding for a head injury. The provider gave an order to transfer the resident to the hospital for evaluation and treatment. 911 was called at 12:04 AM on [DATE]. After calling 911, LPN #1 went to Resident #4's room and observed the resident lying flat on the floor stomach down. LPN #2 was applying pressure to Resident #4's forehead for a laceration which was bleeding and did not move the resident due to a head injury. Resident #4 had agonal respirations and was not responding to verbal commands. The pulse oximeter showed no reading, but a manual pulse check was 68. 911 arrived at the facility at 12:12 AM. Resident #4 was placed on a stretcher by Emergency Medical Services (EMS) and coded at 12:18 AM.<br><br>2.LPN #2 wrote a witness statement at 11:30 AM on [DATE], stated resident laying headfirst on ground-breathing became apneic. EMT arrives-CPR started.<br><br>(continued on next page) |

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| F 0726<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Some | A review of Resident #4's Ambulance Run Record dated [DATE], indicated the EMS team was on scene at 12:12:35 AM, and reached the resident at 12:15:30. EMS narrative reported, upon arrival the patient was found unresponsive, lying prone [on stomach] on the floor with [pronoun] head slightly looking to the left, and [facility name] staff applying pressure dressing to [pronoun] forehead. The patient had weak, agonal respirations with an extremely slow, faint pulse. The patient was found unresponsive with a GCS [Glasgow Coma Scale] of 3. A slow, faint, thready carotid pulse was palpated initially. [Pronoun] airway was open and patent with no vomit or secretions noted in or around [pronoun] mouth or nose. Trachea appeared midline and there was no JVD [Jugular Vein Distention] noted. [Pronoun] had shallow, agonal respirations at 8 breaths/min. with no visual chest rise or fall. Cyanosis [bluish tint to the skin or nail beds indicating a lack of oxygen in the blood] was noted to [pronoun] face and peripheral extremities, but [pronoun] skin was otherwise warm and mottled. The patient's pupils [were] equal and sluggish to respond.<br><br>During an interview on [DATE] at 1:00 PM, LPN #1 stated, she and LPN #2 did not want to move the resident related to trauma but turned Resident #4's head to the side so the resident's face was not in the pillow.<br><br>During an interview on [DATE] at 1:27 PM, LPN #5 stated she was new, but not aware of any emergency equipment or where it was kept. LPN #5 asked LPN #6 for assistance in locating the emergency equipment. LPN #6 stated that the facility had oxygen, but did not think they had an Ambu bag [a medical tool which forces air into the lungs of patients who have either ceased breathing completely or who are struggling to breathe properly]. LPN #5, LPN #6, then joined by LPN #4 all entered the medication room. No Ambu bag was located. LPN #4 stated that she had seen one on another unit and it might be in the treatment cart. Given Resident #4's scenario, LPN #6 stated agonal breathing would be considered a respiratory code and stated if an Ambu bag was available it should be utilized in a respiratory code. LPN #5 and LPN #6 stated they were CPR certified, LPN #4 stated she had let her certification lapse.<br><br>During a concurrent observation and interview on [DATE] at 1:40 PM, the DON stated the facility had an AED [automated external defibrillator], and a mask was kept with it. The facility had oxygen tanks, oxygen concentrators, and she was 99% sure of an Ambu bag. The DON stated during a medical emergency, 911 should be called, then the AED and Ambu bag or mask should be taken to the resident's room. The DON stated, all nurses currently working in the facility are not CPR certified, but it will be required. The facility is looking for someone to help with that. The DON stated that semi-Fowlers would be ideal for someone in respiratory distress and lying on their stomach would compromise their breathing more. At 1:46 PM, the DON took this surveyor to the medication room; an empty plastic bag was hanging on a metal shelfing unit which was where the Ambu bag was to be kept. No Ambu bag was located and the DON stated only one at a time was kept in the facility. This surveyor indicated LPN #4 thought one was located on a treatment cart. At 1:49 PM, an Ambu bag was located inside the treatment cart of a medication room on a back unit. At 1:52 PM, the DON took this surveyor to the front common area close to the dining room where an AED was in a box on the wall. Inside the box was a one-way valve mask for rescue breathing. A tag with monthly check going back over a year was attached to the AED. The DON stated nursing did not check the AED, it was the maintenance department.<br><br>(continued on next page) |

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| F 0726<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Some | During an interview on [DATE] at 2:19 PM, the Medical Director stated he believed all the nursing staff had to have BLS certification, but was unaware of what emergency equipment was available in the facility. He thought there was an AED but was unaware of its location. When questioned about Resident #4's medical emergency the Medical Director stated, breathing takes priority over any trauma. The staff should have intervened to assist with breathing. Resident #4 should have been repositioned supine (on back) and bagged with the agonal breathing.<br><br>During an interview on [DATE] at 4:03 PM, the RN Educator stated the facility did not have any CPR reference cards available to the nurses for quick access instructions. She stated the facility was working on CPR training for everyone.<br><br>During a follow-up interview on [DATE] at 1:02 PM, LPN #1, stated she had worked here about a year and did not feel she was properly trained for an emergency in the facility setting and had never been part of a mock code for training purposes. She stated she was CPR certified, but no assignments were made each shift to identify a charge nurse or code team. LPN #1 was aware an AED was available in the facility but was not aware of a one-way valve mask or an Ambu bag to provide respirations to a resident. LPN #1 stated, if she had access to an Ambu bag the night Resident #4 required emergency services, she would have used it with the resident.<br><br>During an interview on [DATE] at 3:25 PM, LPN #7 stated in a code situation she would start CPR, but no staff members were designated to any code team during each shift. She was aware of the AED and its location, but stated the facility did not have an Ambu bag. She felt she was trained, but stated the staff did not do it very often and it was a high stress situation.<br><br>During an interview on [DATE] at 3:36 PM, the Administrator stated, staff were not required to have CPR certification but thought they had it from nursing school. He stated the human resources department, nor the DON tracked which staff members in the facility were certified. The previous DON had a list, and they were looking for it. The facility did not in-service on their CPR protocol but had an outside instructor in the facility who held a CPR class in April of 2024. No charge nurse was specified during a shift and no code team assignments were made. Nurses had radios they could use to call for assistance from other staff. The facility was working towards getting everyone CPR certified.<br><br>During an interview on [DATE] at 3:42 PM, the DON stated that the CPR policy was not given out to employees at hire, but it would be good moving forward. There was a policy binder located at the front nurses' station, and the policy was located inside it. There were no code team duties assigned for each shift, the emergency equipment was not easily accessible, and there were no mock codes done for training. The DON stated until this surveyor brought it to her attention, she was unaware how inaccessible the equipment was. The CPR policy was part of the nurses ' training but moving forward the DON planned to elaborate more. The DON stated there were two (2) types of codes, a cardiac and respiratory. Resident #4 was likely having a respiratory code and should have been rolled over on [pronoun] back, an Ambu bag used to rescue breathing, and the AED applied to analyze the resident's rhythm.<br><br>During an interview on [DATE] at 2:02 PM, the Administrator stated the facility was aware of one (1) CNA employed who had their CPR certification. The only nursing staff they were aware of who had their BLS certification were those who signed into the [DATE] BLS class at the facility. The facility kept no list of CPR certification.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045125 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 03/06/2025 |
|---|---|---|---|
| NAME OF PROVIDER OR SUPPLIER Butterfield Trail Village | | STREET ADDRESS, CITY, STATE, ZIP CODE 1923 East Joyce Blvd Fayetteville, AR 72703 | |

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

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|---|---|
| F 0726<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Some | During an interview on [DATE] at 3:00 PM, the DON stated, she felt like she had received the proper training for medical emergencies and the equipment, but she could not speak for every employee in the facility. Related to Resident #4's situation the DON stated, a bad decision was made by the first nurse on the scene and the staff did not understand what equipment was available to assist them in the situation.<br><br>During an interview on [DATE] at 3:10 PM, the Administrator stated he felt the staff were trained and competent to handle medical emergencies quickly. He stated maybe we need more in-service and return demonstration. The facility did not have a checkoff for emergency care or CPR qualifications, and he did not believe the DON did either. They are licensed I would assume CPR is nursing 101. No facility competencies are measured or recorded. |