STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045125	A. Building B. Wing	07/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Butterfield Trail Village	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.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 42016 Based on observations, interviews, record review, and facility document review, it was determined the facility failed to ensure dignity was maintained when providing wound care for 1 resident (Resident # 42) and when administering an insulin injection for 1 resident (Resident # 11). Findings include: A review of a facility document titled, Patient's [NAME] of Rights, undated, indicated, .2. Will be treated with consideration, respect, and full recognition of his/her dignity and . including privacy in treatment and in care of my personal needs . 9. Is assured confidential treatment of his/her personal and medical records .15. May have needs .accommodated .staff behaviors to assist residents in maintaining .dignity . 1. A review of the Detailed Summary, indicated the facility admitted Resident #42 with a diagnosis that included Alzheimer's Disease. The quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 06/27/2024 revealed Resident #42 had a Brief Interview for Mental Status (BIMS) score of 6 which indicated the resident had severe cognitive impairment. Section M1040 revealed Resident #42 had skin tears. A review of Resident #42's Care Plan, dated 06/10/2024 revealed the resident required minimal to moderate assistance related to Alzheimer's/Demetia disease progression. Interventions included activities of daily living (ADLs) would be completed while maintaining resident's dignity. A review of the Physician's Orders for 07/2024 revealed Resident #42 had treatment orders for a skin tear on the left forearm, near the elbow. Treatment included cleansing the wound, covering the bed of the wound with petroleum-based gauze and covering it with a foam dressing. A review of the Skin Evaluation Form, dated 07/08/2024, revealed Resident #42 had a skin tear to left forearm, near elbow, with a length of 1.6 centimeters and a width of 0.2 centimeters. No depth was documented. (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the Treatment Record for 07/2024 revealed Resident #42 had a treatment done on 07/08/2024. During an observation on 07/08/2024 at 11:30 AM, Resident #42 was sitting in the dining room on the secure unit. Licensed Practical Nurse (LPN) #2 was sitting with Resident #42 at a table applying a dressing to Resident #42's left arm. Other residents were in the dining room. During an interview on 07/08/2024 at 12:04 PM, Licensed Practical Nurse (LPN) #2 stated the dressing should not have been changed at the table due to privacy of care and dignity of the resident with other residents being in the dining room. 2. A review of the Detailed Summary, indicated the facility admitted Resident #11 with diagnoses that included dementia, cognitive communication deficit, age related macular degeneration, and diabetes mellitus type 2. Review of the quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 05/16/2024, revealed Resident #11 had a Brief Interview for Mental Status (BIMS) score of 5 which indicated the resident had severe cognitive impairment. The MDS indicated Resident #11 had impaired vision, and active diagnoses that included age related macular degeneration, Alzheimer's disease, and diabetes mellitus that required treatment with insulin. A review of Resident #11's Care Plan, undated, revealed the resident altered thought process related to Alzheimer's disease, impaired vision related to macular degeneration and diabetes. Interventions included administering medications per physician's orders, closing the door to minimize distractions, activities of daily living (ADLs) will be completed while maintaining dignity, and respect resident rights. A review of the Physician's Orders for 07/11/2024, revealed Resident #11 was to receive regular insulin injections three times daily for type 2 diabetes mellitus. A review of the Medication Record for 07/2024, revealed Resident #11 received 2 units of regular insulin in the left lower quadrant (LLQ). During a concurrent observation and interview on 07/10/2024 at 12:05 PM, Licensed Practical Nurse (LPN) #4 took Resident #11 into the resident's room. Resident laid on back, across bed. LPN #4 raised the resident's shirt upward and the resident's pants downward exposing Resident #11's abdomen. LPN #4 then injected insulin into Resident #11's left lower quadrant. The blinds on the resident's window were not closed, exposing the resident to the parking lot and vehicles facing the window. The Resident's door was open exposing the resident to the view of other resident sitting at dining tables in the dining room. LPN #4 stated privacy should have been provided for dignity reasons and that by leaving the door open, people in dining room were able to see the care being given. During an interview on 07/10/2024 at 7:47 AM, the Infection Preventionist (IP) stated it was not appropriate to change dressing in the dining room where other residents could see a treatment as it is a dignity and privacy issue for the resident. During an interview on 07/11/2024 at 11:02 AM, the Director of Nursing (DON) stated wound care should not be performed in the dining room at a dining table due to dignity. Privacy should be provided during wound care and insulin administration. Residents should be taken somewhere private with the door closed and the curtain or blinds closed.

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F 0661 Level of Harm - Potential for minimal harm Residents Affected - Some	Ensure necessary information is communicated to the resident, and receiving health care provider at the time of a planned discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39316 Based on record review and interview, the facility failed to ensure a discharge summary was provided for 1 (Resident #45) of 1 sampled resident to ensure education, a recapitulation of the resident's stay, and reconciliation of all pre- and post-discharge instructions were provided and to ensure clarification. The findings are: Review of a facility policy titled, Transfer or Discharge, Preparing a Resident for, dated December 2016, indicated Residents will be prepared in advance for discharge. When a resident is scheduled for transfer or discharge, the business office will notify nursing services of the transfer or discharge so that appropriate procedures can be implemented. A post-discharge plan is developed for each resident prior to his or her transfer or discharge. This plan will be reviewed with the resident, and/or his or her family, at least twenty-four (24) hours before the resident's discharge or transfer from the facility. Nursing services is responsible for: obtaining orders for discharge or transfer, as well as the recommended discharge services and equipment; preparing the discharge summary and post-discharge plan; preparing the medications to be discharged with the resident (as permitted by law); and providing the resident or representative (sponsor) with required documents (i.e., discharge summary and plan). A review of a Profile Face Sheet, indicated the facility admitted Resident #45 with a diagnosis of transient cerebral ischemic attack (a brief stroke-like attack). The quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 02/15/2024, revealed Resident #45 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident was cognitively intact. There was no active discharge planning occurring for the resident to return to the community. A review of Resident 45's Physician Orders, revealed an order dated 04/18/2024 for may discharge home for a three day trial and may remain home if trial successful. Review of Resident #45's Care Plan, with a start date of 12/12/2023, revealed the resident desires discharge to non-nursing home level of care. Family/Caregiver supportive of discharge. Interventions included provide written and oral direction for plan of care including med regime to resident and caregiver; initiated 12/12/2023; document all discharge planning and teaching in Social Service, therapy and/or nursing notes; retain copy of information provided to resident and caregiver; initiated 12/12/2023. On 07/10/2024 at 12:19 PM, an interview with the Director of Nursing (DON) revealed there was not a discharge summary for Resident #45. The DON revealed the facility was required to do a discharge summary and that the nurse on the floor at the time of discharge should have done it. (continued on next page)

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F 0661 Level of Harm - Potential for minimal harm Residents Affected - Some	On 07/11/2024 at 9:02 AM, the Social Worker revealed during an interview, Resident #45 was admitted on [DATE] and discharged on [DATE] after a hospital stay, also, it was planned for Resident #45 to return to her apartment in independent living, and that the resident and or the caregiver should be provided a copy of the discharge summary for educational purposes, especially medications.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. 49071 Based on observation, interview, and record review the facility failed to ensure oxygen was administered only when ordered by a physician to prevent potential respiratory complications for 1 (Resident #9) of 1 sampled resident. The findings are: A review of a facility policy titled, Medication and Treatment, dated July 2016 indicated, .1. Medications shall be administered only upon the written order of a person licensed and authorized to prescribe such medications in this state. A review of a facility policy titled, Medication Orders, dated November 2014 indicated, .3. Oxygen orders - When recording orders for oxygen, specify the rate of flow, route, and rationale . A review of Resident #9's Detailed Summary form indicated the facility admitted Resident #9 on 10/27/2009 with coronary obstructive pulmonary disease, and congestive heart failure. A review of the annual Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 05/30/2024, documented Resident #9 scored 15 (13-15 indicates cognitively intact) on a Brief Interview for mental Status (BIMS) and received oxygen therapy. A review of Physician's Orders, revealed Resident #9 had no order to administer oxygen therapy. A review of Medication Administration Record revealed Resident #9 had no order to administer oxygen therapy. A review of Resident #9's Care Plan revealed, .Assess respiratory status. Hospice nurse may order oxygen 1-4 liters via nasal cannula PRN [as needed] or continuous to maintain comfort unless otherwise contraindicated. If ineffective, may titrate upward per physician orders intervals until symptoms relief. May check pulse oximetry PRN for respiratory assessment. Hospice nurse may suction oral-pharyngeal area PRN for excessive secretions . Implemented:12/04/2023. 1. During an observation on 07/08/2024 at 11:53 AM, the surveyor observed Resident #9 with oxygen via nasal cannula being administered at 5 liters per minute. 2. During another observation on 07/09/2024 at 9:07 AM, and 3:08 PM, the surveyor observed Resident #9 receiving oxygen via nasal cannula at 5 liters per minute. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. During interview on 07/10/2024 at 8:50 AM, Registered Nurse (RN)#1 revealed the nurse is responsible for making sure a resident has orders for a medication. This is done on admission or if there is a change in the resident's condition, a new order is indicated. RN #1 confirmed that receiving oxygen without an order can damage the lungs. The surveyor accompanied RN #1 to Resident #9's room. The RN #1 confirmed Resident #9 was having oxygen administered at 4.5 liters per minute via nasal cannula. The surveyor asked RN #1 to identify the order stating how much oxygen that Resident #9 should be receiving. RN #1 replied that there was no order for the resident to be wearing oxygen and the last assessment with a pulse ox was completed on July 3, 2024, at 1:02 PM. The surveyor asked, How do you know what rate to set a resident's oxygen at? RN #1 replied, We follow the physician's order. The surveyor asked, if you have no order, how do you know what to set a resident's oxygen at. RN #1 replied, We don't. 4. During an interview on 07/10/2024 at 9:02 AM, the Director of Nursing (DON) said the nursing staff and the physician were responsible for making sure a resident had an order for medication. Orders are obtained on admission or if there is a change in their disease process. The Surveyor and the DON went to Resident #9's room. The DON confirmed Resident #9 was receiving oxygen at 4.5 liters via nasal cannula. The surveyor asked the DON to identify what Resident #9's oxygen should be set on. The DON replied that there was no order for Resident #9 to have oxygen administered. The surveyor asked if a resident should have oxygen administered with no physician order. The DON replied that a resident should not be having oxygen administered without an order.

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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. 42016 Based on observations, interviews, record review, and facility document review, it was determined the facility failed to maintain infection control practices as evidenced by wound care being provided to a resident sitting at a dining table for 1 (Resident # 42) of 1 resident observed with wounds. Findings include: A review of a facility document titled, Infection Control Goals of Infection Control and Prevention, undated, indicated, .2. Minimize opportunity for transmission of pathogens. 3. Apply current scientifically accepted infection prevention and control principles appropriate for the specific work environment .The Chain of Infection .The mode in which the organism travels to infect others .All environmental and working surfaces must be promptly cleaned and decontaminated after contact with blood or OPIM (other potentially infectious materials) .Transmission of infections is largely via hand contact with a surface . disinfecting environmental surfaces is fundamental to reducing infections . A review of the Detailed Summary, indicated the facility admitted Resident #42 with diagnoses that included Alzheimer's disease and type 2 diabetes. The quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 06/27/2024, revealed Resident #42 had a Brief Interview for Mental Status (BIMS) score of 6 which indicated the resident had severe cognitive impairment and skin tears. A review of Resident #42's Care Plan, dated, 06/10/2024 revealed the resident was at risk for skin breakdown related to diabetes. Interventions included administering treatments per physician's orders and practice good infection control. A review of the Physician's Orders for 07/2024, revealed Resident #42 had treatment orders for a skin tear on the left forearm, near the elbow. Treatment included cleansing the wound, covering the bed of the wound with petroleum-based gauze and covering it with a foam dressing. A review of the Skin Evaluation Form, dated 07/08/2024, revealed Resident #42 had a skin tear to left forearm, near elbow, with a length of 1.6 centimeters and a width of 0.2 centimeters. No depth was documented. A review of the Treatment Record for 07/2024, revealed Resident #42 had a treatment done on 07/08/2024. During an observation on 07/08/2024 at 11:30 AM, Resident #42 was sitting in the dining room on the secure unit. Licensed Practical Nurse (LPN) #2 was sitting with Resident #42 at the table applying a dressing to the left arm. No barrier was on the table for supplies and the table was not cleaned or disinfected after the dressing change. During an interview on 07/08/2024 at 11:45 AM, Resident #42's family member stated Resident #42 scratched their left arm and is on a blood thinner and picks at scabs until it bleeds. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 07/08/2024 at 11:56 AM, residents were in the dining room and others were entering the dining room and being served beverages at the dining tables. During an interview on 07/08/2024 at 12:04 PM, Licensed Practical Nurse (LPN) #2 stated the dressing should not have been changed at the table due infection control issues, specifically contamination of the table. LPN #2 stated the dressing should have been changed earlier in the resident's room when it was bleeding. During an interview 07/10/2024 at 7:47 AM, the Infection Preventionist (IP) stated it is not appropriate to change the dressing in the dining room. It is a dignity issue and an infection prevention issue. Food could contaminate the wound and, the wound; exposing the place where residents eat to contaminates. During an interview on 07/11/2024 at 11:02 AM, the Director of Nursing (DON) stated wound care should not be performed in the dining room at a dining table due to dignity and the potential for bacteria transmission. The table should have been cleaned after the wound care. Privacy should be provided during wound care. The resident should be taken somewhere private with the door closed and curtains or blinds closed.