STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045170	A. Building B. Wing	12/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Green House Cottages of Belle Meade	2200 Chateau Boulevard Paragould, AR 72450

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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43262 Based on observations, record review, document review, and interviews, the facility failed to ensure staff followed a resident's care plan, as evidenced by Resident #1 sliding off the side of the bed while 1 staff assisted with dressing, despite the care plan indicating the need for 2 staff, for 1 (Resident # 1) sampled resident. The failed practice resulted in noncompliance at the level of immediate jeopardy (IJ), which caused major injury to Resident # 1, who was at high risk for falls. It was determined the facility's non-compliance with one or more requirements of participation had caused, or was likely to cause, serious injury, harm, impairment, or death to residents. The Immediate Jeopardy (IJ) was related to State Operations Manual, Appendix PP, 483.25 Accidents and Hazards (to provide appropriate and sufficient supervision to each resident to prevent an avoidable accidents) at a scope and severity of J. The IJ began on 12/12/2024 at 7:15am, when Resident #1 was being assisted with getting dressed by 1 staff person, when the staff person sat the resident up on the side of the bed while waiting for the 2nd staff person to come help, at which point the resident slid to the floor, resulting in hospitalization , a broken femur, and surgical repair of the injury. The Administrator, Assistant Administrator, and Nurse Consultant were notified of the immediate jeopardy on 12/18/2024 at 1:53 PM. A Plan of Removal (POR) was requested. The POR was accepted by the State Survey Agency (SSA) on 12/19/2024 at 9:23am. The findings are: A review of an Admission Record indicated the facility admitted Resident #1 with medical diagnosis of dementia, unspecified severity, without behavioral, psychotic, or mood disturbances, and anxiety. The admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 08/12/2024 revealed Resident # 1 scored 4 (0-7 indicates severe cognitive impairment) on a Brief Interview for Mental Status (BIMS) and exhibited the need for maximum (max) assistance with dressing their upper body. (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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NAME OF PROVIDER OR SUPPLIER: The Green House Cottages of Belle Meade		STREET ADDRESS, CITY, STATE, ZIP CODE: 2200 Chateau Boulevard Paragould, AR 72450	

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Review of Resident # 1's Care Plan, initiated 11/27/2023, revealed the resident's usual performance is requiring max assistance with Activities of Daily Living (ADLs) related to cognitive impairment, incontinent of bowel and bladder, wheelchair for mobility, and required a mechanical lift for transfers. Resident is dependent of 2 staff with upper body dressing. Care Plan initiated 8/17/2023 and revised on 10/15/2024 indicated resident was at risk for falls and had a history of falls. A review of a nursing Progress Note, dated 12/12/2024 at 07:15am, revealed Resident #1 had fallen off the bed and into the floor, landing on her left side, after a Certified Nursing Assistant (CNA) had the resident sit on the side of the bed in order to assist dressing upper body. The progress note indicated resident was complaining of pain in left hip. An Incident and Accident (I & A) was completed, Advanced Practice Registered Nurse (APRN) was notified, and x-rays were ordered. Family and Administrator were also notified. A review of a nursing Progress Note, dated 12/12/2024 at 10:18pm, revealed Resident #1 was hospitalized . A review of a nursing Progress Note, dated 12/16/2024 at 7:03pm, revealed Resident # 1 returned to the facility earlier that day at 4:45pm with oxygen being administered at two liters due to blood oxygen levels not staying at normal range, a catheter due to urinary retention, a prescription for Norco due to the resident groaning in pain, and a surgical site to left hip where the femur had been surgically repaired. A review of Administrator's Internal Investigation, dated 12/12/2024 following the incident involving resident #1, in-services were provided to facility staff pertaining to, Following Care Plans, How to read a Kardex, and How to operator a mechanical lift. (A Kardex is a brand name for an informational filing system that is used as a quick reference for nurses. It's a desktop file system that gives a brief overview of each patient and is updated every shift.) A review of a witness statement within investigation packet dated 12/13/2024 by CNA #1 indicated that she sat the resident up on the side of the bed, and then went and asked another CNA for help. CNA #1 stated that the resident tried to stand up and fell to the floor. A review of a witness statement within the investigation packet dated 12/12/2024 by Licensed Practical Nurse (LPN) #3 indicated that CNA #1 had Resident #1 sitting on the side of the bed, which was raised to hip level, lift pad placed in wheelchair, and lift wasn't inside the resident's room. LPN #3 stated in the witness statement that it appeared as though CNA #1 was attempting a transfer by herself without using the lift. A review of a witness statement dated 12/12/2024 by CNA #2 indicated that CNA #1 had come into the room where CNA #2 was at and asked for help. CNA #2 stated that she would be right there to help as soon as she could. CNA #1 returned to the room where CNA #2 was a few minutes later and stated that the resident had fallen into the floor. CNA #2 stated that upon entry to Resident #1's room, the lift pad was in the resident's chair instead of on the bed and the lift was located outside the room in the hallway and it appeared as though CNA #1 had attempted to transfer the resident by herself rather than using the lift with the assistance of another staff. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	In an interview on 12/18/2024 at 08:33am with LPN #3, she confirmed that she was familiar with Resident #1 and their care plan, conducted weekly body audits, Braden scales, and assessments. LPN #3 confirmed she was working the day Resident #1 fell and that it was CNA #2 that reported the fall. LPN #3 stated that staff received in-services following the incident and that Resident #1 already had fall mats in place and was unsure if anything was added as an intervention. LPN #3 stated that changes in resident's care are communicated verbally. LPN #3 confirmed that staff receive retraining and in-services on falls, lifts, and transfers as needed and that the [NAME] house always has 3 staff on duty. In an interview on 12/18/2024 at 08:41am with CNA #2, she confirmed that all the CNAs work closely together but she has never witnessed an incident due to abuse or neglect of a resident. CNA #2 did not think that any injury occurred due to low staffing and staff mannerisms are always professional. CNA #2 stated that in order to find out changes in a resident's care, needs, or interventions, they look at the Cardex. CNA #2 stated that she is familiar with Resident #1's care and that she was working the day the resident fell . CNA #2 said that CNA #1 had come in the room where she was working and asked for help. CNA #2 told CNA #1 that she would be in there as soon as she could but before she could get in there, CNA #1 came and told her that Resident #1 had fallen off the bed and was in the floor. CNA #2 called the nurse, and that Resident #1 was complaining that her left hip was hurting. CNA #2 said that resident was a 1 person assist with dressing and 2-person using a lift for transfer but since the incident, she is a 2 person assist with all Activities of Daily Living (ADL's). CNA #2 said she feels like there is enough staff during the day but due to some of the dementia residents having sundowner's syndrome, she wishes there were more staff at night. (Sundowning, or sundown syndrome, is a neurological phenomenon wherein people with delirium or some form of dementia experience increased confusion and restlessness beginning in the late afternoon and early evening.) In an interview on 12/18/2024 at 08:53am with CNA #1, CNA #1 confirmed that the Cardex is where information about resident's care, needs, and interventions were found. CNA #1 stated that she was familiar with Resident #1's care and on the morning that the resident slid out of bed, CNA #1 had just given her a bed bath and was dressing resident's upper body when she sat her up on the side of the bed and the resident tried to stand up and fell . CNA #1 stated that there were only 2 CNAs working the [NAME] house that morning and she had gone to get CNA #2 to help get resident dressed. CNA #1 said she feels like there needs to always be 3 CNAs in the house. CNA #1 stated that staff receive monthly check offs on lifts and transfers as well as quarterly in-services on patient care. On 12/18/2024 at 12:30pm, in a 2nd interview with CNA #1, CNA #1 stated that Resident #1's bed at the time of the incident was lowered all the way down, as far as it could go, maybe just a little bit higher. CNA #1 said that the resident's feet were touching the floor. On 12/18/2024 at 12:36pm in a 2nd interview with CNA #2, CNA #2 confirmed that the position of Resident #1's bed at the time of the incident was upper thigh to possibly waist high. CNA #2 confirmed that resident's feet could not have touched the floor and that the bed should have been in the lowest position. Removal Plan: (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	On 12/13/2024, the Interdisciplinary Team changed resident #1 upper body dressing assistance from 1 staff assist to 2 staff assist. When resident #1 returned to the facility on [DATE], staff was educated of Resident #1 changing from a 1 person assist to 2-person assist with upper body dressing ADL. On 12/18/2024 at 3:08 p.m., the Administrator was notified of an immediate jeopardy level deficiency of alleged failure to provide adequate supervision and assistance to prevent accidents by failing to ensure resident assisted with Activities of Daily Living (ADLs) with the number of staff members required according to the resident's assessed needs. On 12/18/2024, the Administrator/Designee immediately initiated an in-service for all direct care staff for following the care plan for ADLs, specifically dressing. All direct care staff will be in-serviced as they report for shift. On 12/18/2024, the Director of Nursing/designee physically assessed all 12 residents who need 2-person assistance with dressing assistance with the potential for neglect with no negative findings. Minimum Data Set (MDS) Coordinators immediately began reviewing all resident ADL care plans for accuracy. Any care plans that required updates were completed immediately. Completion date of 12/18/2024 Director of Nursing/Designee monitored ADL care by observation of 6 residents to ensure staff is following care plan for ADL assistance to prevent accidents. This was initiated and completed on 12/18/2024 with no negative findings. Administrator/Designee will provide a binder to each cottage identifying residents who require 2 persons assist with ADLs. Completion date of 12/18/2024. On 12/19/2024, the Director of Nursing/designee initiated an in-service for all direct care staff that bed height is appropriate for resident and staff during dressing ADLs. All corrections were completed on 12/19/2024. The Plan of Correction (POC) was accepted on 12/19/2024 @ 9:23am. Onsite Verification: On 12/13/2024, the Interdisciplinary Team changed Resident #1 upper body dressing assistance from 1 staff assist to 2 staff assist. When Resident #1 returned to the facility on [DATE], staff was educated of Resident #1 changing from a 1 person assist to 2 person assist with upper body dressing ADL. On 12/18/2024, the Administrator/Designee immediately initiated an in-service for all direct care staff for following the care plan for ADLs, specifically dressing. All direct care staff will be in-serviced as they report for shift. On 12/19/2024, the Director of Nursing/Designee initiated an in-service for all direct care staff that bed height is appropriate for resident and staff during dressing ADLs. (continued on next page)

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