STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045176	A. Building B. Wing	09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Woods, A Nightingale Community	1194 N Chester St Monticello, AR 71655

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 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. 48390 Based on interviews and record review, it was determined the facility failed to notify the State of Long Term-Care Ombudsman in writing of a transfer to the hospital for 1 resident (Resident #1) reviewed for hospitalization . Findings include: A review of a facility policy titled: Transfer and discharge date d 09/26/24 at 11:10 AM provided by Administrator indicated, .The nursing facility shall send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. On 09/26/24 the Administrator was asked to provide proof that the State Ombudsman had been notified of Resident #1 hospitalization s. A review of the Census tab for Resident #1's electronic health record indicated the resident was sent to the hospital four times between the dates 05/23/2024 and 09/05/2024. On 09/26/24 at 12:10 PM, the Administrator reported she was having trouble getting into Assistant Director of Nursing's computer to locate notifications sent to State Ombudsman. On 09/26/24 at 1:40 PM, Director of Nursing reported the Administrator was working on getting the transfer/discharge notifications sent to the State Ombudsman. During an interview on 09/26/24 at 3:34 PM, the Administrator indicated she was now responsible for sending the transfer/discharge letter to the State Ombudsman. The Administrator indicated that before her it was either the Business Office Manager or the Assistant Director of Nursing that sent the letter to the State Ombudsman. The Administrator was not able to provide proof that notification had been sent to the State Ombudsman for the four times Resident #1 had been hospitalized .

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 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. 37925 Based on observation, record review and interview, the facility failed to ensure an assistive communication device was utilized to facilitate communication between a resident and staff for 1 (Resident #3) sampled resident who required an assistive communication device. The findings are: Resident #3's Medical Diagnosis record was reviewed and indicated diagnoses of an opening in the neck and into the windpipe tracheostomy) an opening in the neck that assists with breathing and abnormal cells in the throat (carcinoma in situ of pharynx). A quarterly Minimum Data Set with an Assessment Reference Date of 07/21/2024 was reviewed and indicated Resident #3 had a Brief Interview for Mental Status score of 13, which indicated the resident was cognitively intact, and had a tracheostomy. Resident #3's plan of care, dated 08/07/2024, was reviewed and indicated the resident had a communication problem and required a [brand name] valve to assist with communication. Staff were to ensure the device was available and functioning. On 09/26/2024 at 9:01 AM, Resident #3 was lying in bed with eyes closed and a tracheostomy (trach) device was observed in resident's neck. There was no assistive communication device observed or valve on the trach. On 09/26/2024 at 10:28 AM, Licensed Practical Nurse (LPN) #1 was interviewed with concurrent observations. Surveyor asked if Resident #3 was able to communicate with staff. He stated he had difficulties understanding the resident, but the resident had a voice box staff could attach to the trach. He was asked where the assistive communication device was located. He stated at the [nursing] desk. He was asked when the assistive communication device was placed on Resident #3. He stated whenever the resident tried to communicate with staff. He was asked if the assistive device was left on the resident. He stated no because the device had been lost before and was in the medication cart when not in use. This surveyor asked to view the device and LPN #1 unlocked the medication cart. In the top drawer, there was a purple, circular container with the words [brand name] Tracheostomy & [and] Ventilator Swallowing and Speaking Valve. Inside the circular container was a small device. LPN #1 placed the assistive communication device back inside the top drawer of the medication cart and locked the cart. On 09/26/2024 at 12:16 PM, Resident #3's call light was on the outside of the room above the doorway was observed and on. The Administrator entered the resident's room and exited the room seconds later and walked to the nursing station. At 12:17 PM, LPN #1 entered the resident's room, and this surveyor followed him. The resident was making sounds from the trach. LPN #1 did not utilize the assistive device to assist the resident in communicating with him. (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 09/26/2024 at 12:39 PM, LPN #1 entered the resident's room, and the resident was making sounds from the trach. The resident pointed to a pair of green boots on both legs. LPN #1 was asked if he knew what the resident needed, and he stated he thought the resident may want the boots taken off, but he was not sure. LPN #1 turned off the call light and exited the resident's room. The assistive communication device was not placed on the trach to assist the resident with communicating the need to LPN #1. On 09/26/2024 at 12:57 PM, the call light above the doorway outside Resident #3's room was observed and on. Certified Nursing Assistant (CNA) #3 entered the room. The resident was making sounds from the trach and no assistive device was utilized. CNA #3 left the room shortly after entering and left the area. On 09/26/2024 at 1:22 PM, Resident #3's call light on the outside of the room above the doorway was observed on from the call light being activated. An un-identified female entered the room, and the resident was making sounds from the trach. The un-identified female stated she would get someone and left the room, leaving the call light on. CNA #3 entered the room, and the resident was making sounds from the trach. CNA #3 turned the light off and exited the room. CNA #3 did not utilize the assistive device to facilitate communication between her and the resident. On 09/26/2024 at 3:45 PM, the Director of Nursing (DON) was interviewed and provided a typed statement regarding instructions provided to the staff for Resident #3's assistive communication device. The statement was reviewed and indicated, I advised that the [brand-name device] was to be utilized when [Resident #3] wanted to communicate and then was to be removed, as this is not worn at all times. The statement indicated the assistive communication device was kept in the medication cart. The DON what asked the purpose of the communication device, and she stated to assist the resident with using words. She was asked if staff took the assistive communication device when they entered the resident's room in the event the resident wanted to communicate with them. She stated staff did not take the device in the room every time.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. 48977 Based on observations, interviews, record review, and facility policy review the facility failed to ensure staff provided proper incontinence care to 1 (Resident #6) sampled resident. The findings include: A review of the significant change Minimum Data Set (MDS) with the Assessment Reference Date of 8/31/2024 revealed Resident #6 had a Brief Interview of Mental Status (BIMS) score of 10, indicating moderate cognitive impairment, and indicated the resident was incontinent of bowel and bladder. A plan of care for Resident #6 (revision date: 9/02/2024) revealed Resident #6 had bowel and bladder incontinence related to disease process and used adult disposable briefs. On 9/25/2024 at 2:00 PM, the Surveyor observed Certified Nursing Assistant (CNA) #4 improperly clean Resident #6. The resident had experienced an incontinence episode, and when CNA #4 cleaned the resident's genital region with wipes, the CNA wiped back to front, a practice that can spread germs and cause urinary tract infections. CNA #4 did not completely clean the resident's genital area. The surveyor observed that liquid waste had soiled the resident's brief, incontinence pad, and the fitted sheet on the bed beneath. CNA #4 did not remove the soiled pad or sheet before rolling the portion of the resident's body that had been wiped clean into it, exposing the resident to the moisture and liquid waste. On 9/25/2024 at 2:12 PM, CNA #4 stated the genitals were not cleaned properly and Resident #6 had urinated through the brief, incontinence pad, and onto the fitted sheet. On 09/26/24 at 1:15 PM, the Director of Nursing (DON) stated the way in which the genitals were cleaned was improper and could cause the resident to have an infection. A policy titled Accident Hazards Prevention noted the facility is responsible for providing care to residents in a manner that helps promote quality of life.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. 37925 Based on observation, interview, and record review, the facility failed to ensure the enteral feed and flush was administered at the physician's ordered rate for 1 (Resident #3) sampled resident who received enteral nutrition and water through a Percutaneous Endoscopic Gastrostomy (PEG) tube. The findings are: Resident #3 's medical diagnosis screen was reviewed and indicated the resident had a diagnosis of difficulty swallowing (dysphagia) and an opening into the stomach wall (gastrostomy status). A quarterly Minimum Data Set with an Assessment Reference Date of 07/21/2024, was reviewed and indicated Resident #3 had a Brief Interview for Mental Status score of 13, which indicated cognitively intact and had a feeding tube. Resident #3's Order Summary Report was reviewed and indicated a physician's order, dated 09/13/2024, for [brand name] enteral feed to be administered at 53 milliliters per hour (ml/hr.) and flush at 40 ml every 1 hour. On 09/25/2024 at 9:01 AM, Resident #3 was observed lying in bed, awake with the head of bed up. The feeding pump displayed feed 43 ml/hr and flush 40 ml (milliliters) every 1 hr. The feeding and flush bags were not labeled at this time. On 09/25/2024 at 2:29 PM, Resident #3 was observed lying in bed on the back with eyes closed. The feeding pump displayed the feed rate of 43 ml/hr. and a flush rate of 40 ml every 1 hr. and was connected to the resident. On 09/26/2024 at 8:10 AM, Resident #3 was observed lying in bed on back with eyes closed and hob up. The feeding pump displayed feed 43 ml/hr. and flush ml every 1 hr. and was connected to the resident. On 09/26/2024 at 10:28 AM, Licensed Practical Nurse (LPN #1) was interviewed with concurrent observations. He confirmed the pump showed 43 ml/hr for the feed rate and 40 ml/hr for the flush rate. He was asked how often the settings on the pump were checked against the orders. He stated daily. He was asked to check Resident #3's orders in the electronic health record (EHR) but was unable to at the time because the facility's internet system was offline. He stated the nurses could use the paper Medication Administration Record (MAR)s. The paper MAR for Resident #3 was reviewed and indicated the document was printed on 08/21/2024 at 12:56 AM. The physician's order on the document indicated the enteral feed rate was 40 ml/hr, and the flush rate was 43 ml/hr. He was asked who updated the paper MARs to ensure the orders were current. He stated he did not know. On 09/26/2024 at 2:20 PM, LPN #5 was interviewed and asked how she knew what the feed/flush rate was for residents receiving enteral feeding. She stated she looks at the MAR to ensure the pump is set according to the MAR. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An enteral feeding procedure guideline, from the [Named] Manual of Nursing Practice 10th edition not dated, provided by the Director of Nursing on 09/26/2024, was reviewed and indicated giving nutrients directly into the stomach was more beneficial than parenteral (giving nutrition through the feeding).

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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. 48977 Based on observations, interviews, record review, and facility policy review, the facility failed to ensure staff used proper hand hygiene while providing care to 1 (Resident #6) sampled resident. The findings include: A review of the significant change Minimum Data Set (MDS) with the Assessment Reference Date of 8/31/2024 revealed Resident #6 had a Brief Interview of Mental Status (BIMS) score of 10 indicating moderate cognitive impairment and was always incontinent of bowel and bladder. A plan of care for Resident #6 (revision date: 9/02/2024) revealed Resident #6 had bowel and bladder incontinence related to disease process and used adult disposable briefs. On 9/25/2024 at 2:00 PM, the Surveyor observed Certified Nursing Assistant (CNA) #4 touch objects in the room such as the bedside drawer with dirty gloved hands while providing care to Resident #6. On 9/25/2024 at 2:12 PM, CNA #4 stated she had touched the handles on drawer and privacy curtains with dirty gloved hands. On 09/26/24 at 1:15 PM, the Director of Nursing (DON) stated the staff member contaminated the items touched with the dirty gloves. A policy titled Infection Control noted perform hand hygiene after contact with bodily fluids, patient's intact skin or with inanimate objects in immediate vicinity of the patient.