

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045190	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/19/2024
NAME OF PROVIDER OR SUPPLIER Nightingale at Crossett		STREET ADDRESS, CITY, STATE, ZIP CODE 1101 Waterwell Road Crossett, AR 71635	

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)
<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>48977</p> <p>Based on observations, interviews, record review, and facility policy review, the facility failed ensure that 1 (Resident #25) sampled resident's dignity was maintained while receiving care.</p> <p>The findings include:</p> <p>Review of the annual Minimum Data Set (MDS) with the Assessment Reference Date (ARD) of 8/30/2024 revealed Resident #25 scored 4 on the Brief Interview of Mental Status indicating severe impaired cognition, and the resident was frequently incontinent of bowel and bladder.</p> <p>A plan of care for Resident #25 (revision date 3/07/2024) revealed Resident #25 had frequent bladder and bowel incontinence related to Alzheimer's and required staff to clean peri-area with each incontinence episode.</p> <p>On 09/18/24 at 9:15 AM, the Surveyor observed Certified Nursing Assistant (CNA) #7 providing Resident #25 with incontinence care with the bathroom door open and curtain unpulled in the presence of the resident's roommate.</p> <p>On 09/18/24 at 9:16 AM, CNA #7 stated, I know I did wrong and confirmed she did not pull that curtain to provide Resident #25 with privacy.</p> <p>On 09/18/24 at 11:30 AM, the Director of Nursing (DON) stated when staff are providing care, they should pull the curtain to protect the privacy and maintain the dignity of the resident.</p> <p>Review of facility policy undated and titled Your Rights and Protection as a Nursing Home Resident noted At a minimum, Federal law specifies that nursing homes must protect and promote the following rights of each resident. You have the right to: Be Treated with Respect: You have the right to be treated with dignity and respect.</p>

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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<p>F 0567</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to manage his or her financial affairs.</p> <p>37925</p> <p>Based on observation, interview, record review, and facility policy review, the facility failed to ensure residents had access to their personal funds through the week and on weekends.</p> <p>The findings are:</p> <p>On 09/16/2024 at 10:45 AM, Resident #30 was lying in bed awake. The resident was asked if the resident had an account at the facility and the resident stated yes. The resident was asked when can money be requested, and the resident stated money could only be requested on Monday, Wednesday and Friday each week. The resident was asked what if money needed to be requested on weekends, what did the resident do and the resident stated no one was there on the weekends for the resident to request money. Resident #41 stated money had to be requested on Friday if needed for the weekend.</p> <p>Resident #30's census in the electronic health record was reviewed and indicated the resident's primary payer source was Medicaid.</p> <p>Resident #30's Order Summary Report was reviewed and indicated the resident had a diagnosis of a loss of muscle function in the lower half of the body (paraplegia).</p> <p>Resident #30's quarterly Minimum Data Set with an Assessment Reference Date of 06/13/2024 indicated the resident had a Brief Interview of Mental Status score of 15, which indicated cognitively intact.</p> <p>Resident 30's last quarterly banking statement was reviewed and indicated on 07/15/2024, a Monday, a debit in the amount of 20 dollars occurred and indicated the payee as resident petty cash. On 08/12/2024, a Monday, a debit in the amount of 80.00 dollars occurred and indicated the payee as resident petty cash.</p> <p>On 09/16/2024 at 11:27 AM, Resident #7 was sitting in a chair and the resident's Family Member (FM #11) was in the room sitting on the resident's bed. The resident was asked if the facility managed a bank account for the resident and FM #11 stated the resident did not have an account and the family handled the resident's personal bank account. FM #11 stated the resident did have a small amount of money in petty cash. FM #11 stated the resident could ask for the resident's money, but only on certain days and a sign was posted on the door regarding the days to request money. The resident stated the days were Monday, Wednesday, and Friday.</p> <p>Resident #7's quarterly Minimum Data Set 3.0 with an Assessment Reference Date of 08/03/2024 was reviewed and indicated the resident had a Brief Interview for Mental Status score of 14, which indicated cognitively intact and diagnoses of cancer and high blood pressure.</p> <p>On 09/16/2024 at 11:36 AM, this surveyor observed signage posted on the Social Service's (SS)s door which indicated banking hours, the 3rd (third), Monday, Wednesday and Friday, 1:00 to 3:00, and did not indicate if the hours were AM or PM.</p> <p>(continued on next page)</p>		

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<p>F 0567</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 09/18/2024 at 3:16 PM, SS was interviewed and asked how residents requested their money on evenings after the office was closed. She stated the nurses could call her, and she could be back at the facility in five minutes. She was asked how residents requested money on weekends when the office was closed and she stated, The same. She was asked what residents did if they wanted access to their funds on Tuesday or Thursday. She stated if the residents came and asked for money, she would go ahead and give them money. She was asked if the residents could ask for their money anytime, why did the signage on the door indicate banking hours were Monday, Wednesday, and Friday. She stated, To cut down on traffic coming in all throughout the day wanting money. She stated, The month prior to changing the banking hours, it was brought it up in a resident council meeting and all the residents agreed.</p> <p>On 09/19/2024 at 9:50 AM, SS was asked to clarify the information posted on the signage on her door regarding the banking hours. She stated, The third of every month is when they get their money, between the first and third, and that's when most of them want their money. Monday, Wednesday and Friday, they [residents] can come between 1 [PM] and 3 [PM] and get their money. She was asked if all the residents with personal bank accounts managed by the facility were in the resident council meeting when the change in banking days was discussed and she stated, not every single one.</p> <p>A document titled, Your Rights and Protections as a Nursing Home Resident, not dated, and provided by the Administrator on 09/19/2024, was reviewed and indicated the resident had certain rights and protections under Federal and state law, had the right to make their own decisions, and the nursing home must allow the resident access to their bank accounts, cash, and other financial records.</p>		

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<p>F 0644</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed.</p> <p>48977</p> <p>Based on record review and interviews, the facility failed to notify the proper state authority when aware that one (Resident #5) sampled Resident had a new diagnosis of a mental disorder.</p> <p>The findings include:</p> <p>According to the quarterly Minimum Data Set (MDS) with the Assessment Referenced Date (ARD) of 7/11/2024 revealed Resident #5 had a Brief Interview of Mental Status (BIMS) score of 05 indicating severe cognitive impairment and had the diagnoses of bipolar disorder and depression.</p> <p>A plan of care for Resident #5 (revision date 11/14/2021) revealed Resident #5 used psychotropic medications related (r/t) behavior management for bipolar disorder, mood disorder, and potential for injury to self and/or others.</p> <p>A review of the form 787 submitted State Designated Professional Associates letter on 8/29/2022 noted Resident #5 had a diagnosis or history of mental illness but did not note the resident had bipolar disorder.</p> <p>On 9/17/24 at 11:35 AM, the Director of Nursing (DON) stated Resident #5 had the following mental illness/disorder: intellectual disorder, major depression, dementia, bipolar disorder, and mood disorder. The DON stated Resident #5 received the diagnosis of bipolar in 2016, and the form 787 was submitted to the State Designated Professional Associates in 2022, did not note bipolar disorder.</p> <p>On 09/18/24 at 11:30 AM, the DON stated the state authority was not notified of Resident #5 new diagnosis of bipolar.</p>

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>48390</p> <p>Based on observation, record review, and interview, the facility failed to ensure nail care was consistently provided to promote good grooming and personal hygiene for 1 (Resident #18) resident reviewed for activities of daily living (ADL) care.</p> <p>The findings are:</p> <p>Review of the Medical Diagnosis portion of Resident #18's health record had diagnoses of hemiplegia (one side paralysis) and hemiparesis (one sided muscles weakness) following cerebrovascular disease affecting left non-dominant side and type 2 diabetes mellitus.</p> <p>A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 07/22/2024, revealed Resident #18 had a Brief Interview for Mental Status [BIMS] score of 3, which indicates the resident has severe cognitive impairment.</p> <p>Resident #18's Care Plan, initiated on 03/28/2023, indicated the resident had an ADL self-care performance deficit related to confusion, dementia, impaired balance, limited mobility, and limited range of motion, and the resident was dependent totally dependent on one staff member to provide bathing/showing on Monday, Wednesday, and Friday and resident was totally dependent on staff for personal hygiene. The care plan also indicated diabetic nail care every Tuesday.</p> <p>On 09/17/2024 at 9:05 AM, Resident #18 was observed lying in bed. The resident had his right hand out from under the cover. Resident had a dark brown substance under the middle, pointer, and ringer fingernails of the right hand. The nail beds around the cuticles of these fingers were discolored with a dark yellow color. Resident #18's right ring fingernail was split, and fingernails extended past the resident's fingertips.</p> <p>On 09/17/2024 at 2:18 PM, Resident #18 was observed lying in bed. Resident had their right hand out from under the cover. Resident's right hand had a dark brown substance under the middle, pointer, and ringer fingernails. The nail beds on residents' right hand were also discolored. Residents right ring fingernail was split, and fingernails were out past the fingertips.</p> <p>On 09/18/2024 at 8:37 AM, Resident #18 was observed lying in bed. Resident showed surveyor their hands. Resident #18's right pointer finger hand a dark brown substance under the fingernail.</p> <p>On 09/18/2024 at 10:00 AM, Certified Nursing Assistant (CNA) #10 was asked to describe what Resident #18's fingernails looked like. CNA #10 indicated it looked like bowel movement. Surveyor asked CNA #10 to describe the color. CNA #10 indicated it was dark brown, resident nails needed to be cleaned and Resident's nail on the right pointer finger was split.</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 09/19/2024 at 10:08 AM, License Practical Nurse (LPN) # 6 was asked to describe how the CNA's care for a hospice resident. LPN #6 indicated that all care is completed by hospice. LPN #6 indicated that if a resident needs to be cleaned up after being changed or have nails cleaned up, the CNA's can and will do that for any resident. LPN #6 indicated that the CNA's are more than happy to step in and help care for any resident. LPN #6 was asked if a CNA can clean a hospice resident's nails. LPN #6 indicated yes. LPN #6 indicated if a Resident is diabetic, CNAs cannot trim the nails but can clean them.</p> <p>On 09/19/2024 at 12:52 PM, the Administrator reported the facility did not have a policy on nail care and provided a memo indicating no policy.</p>		

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.</p> <p>37925</p> <p>48977</p> <p>Based on observation, interview, record review, and facility document review. the facility failed to ensure an indwelling catheter tube was secured to a resident's leg for 1 (Resident #41) of 1 sampled resident who was reviewed for an indwelling catheter and failed to ensure that 1 sampled (Resident #25) resident received proper incontinence care.</p> <p>The findings are:</p> <p>1. On 09/16/2024 at 11:05 AM, Resident #41 was observed lying in bed and a catheter bag was hooked on the right side of the bed frame in a privacy bag. Resident #41 was asked if anything was on either leg to keep the catheter in place. The resident pulled the blanket back and there was no device to secure the indwelling catheter tubing to either of the resident's legs.</p> <p>On 09/16/2024 at 11:20 AM, Certified Nursing Assistant (CNA) #1 was interviewed with concurrent observations and she was asked to look at Resident #41's indwelling catheter tubing and see if the tubing was secured to either of the resident's legs. CNA #1 confirmed there was no device on either leg to secure the resident's indwelling catheter tubing. She was asked who was responsible for placing a device on the resident's leg to secure the indwelling catheter tubing and she stated the nurses placed them on the residents.</p> <p>Resident #41's admission Minimum Data Set with an Assessment Reference Date of 07/29/2024 was reviewed and indicated the resident had a Brief Interview of Mental Status score of 12, which indicated moderately impaired and had an indwelling catheter.</p> <p>Resident #41's 'Order Summary Report' was reviewed an order dated 07/23/2024 indicated every shift was to verify placement of the [brand name] catheter leg band or [brand name] device.</p> <p>Resident #41's plan of care, dated 08/07/2024, was reviewed and did not have an intervention to indicate the indwelling catheter tubing should be secured to the resident's leg.</p> <p>Review of a document the procedure guidelines 21-2 exert from (Named) Manual of Nursing Practice 10th Edition, not dated, titled Catheterization of the Urinary Bladder and provided by the Administrator on 09/19/2024, indicated on page 781 the indwelling catheter should be secured to the patient's thigh using tape, strap, adhesive anchor or other securement device.</p> <p>2. Review of the annual Minimum Data Set (MDS) with the Assessment Reference Date (ARD) of 8/30/2024 revealed Resident #25 scored 04 on the Brief Interview of Mental Status indicating severe impaired cognition and was frequently incontinent of bowel and bladder.</p> <p>A plan of care for Resident #25 (revision date 3/07/2024) revealed Resident #25 had frequent bladder and bowels incontinence related to Alzheimer's and required staff to clean perineal area with each incontinence episode.</p> <p>(continued on next page)</p>		

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 09/18/24 at 09:15 AM, the Surveyor observed CNA #7 stand performing care to Resident #25 and noted CNA #7 did not clean the genital area.</p> <p>On 09/18/24 at 09:16 AM, CNA #7 stated I know I did it wrong, and confirmed she did not clean the front of the resident.</p> <p>On 09/18/24 at 11:30 AM, the Director of Nursing (DON) stated when staff are providing incontinence care to a resident they should clean the genital area to prevent infection, maintain the dignity of the resident, and promote cleanliness.</p> <p>A policy titled Perineal Care instructed staff to remove irritating and odorous secretions, to prevent extended skin exposure to incontinence of urine/feces, and to thoroughly clean the genital area of male and female residents.</p>

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<p>F 0693</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p>37925</p> <p>Based on observation, record review, interview, and facility policy review, the facility failed to ensure a Percutaneous Endoscopic Gastrostomy (PEG) tube (a feeding tube inserted through the belly and into the stomach) was checked to verify the tube was in the stomach before use for 1 (Resident #1) of 1 sampled resident reviewed for a PEG tube.</p> <p>The findings are:</p> <p>On 09/18/2024 at 8:29 AM, Licensed Practical Nurse (LPN) #6 was interviewed with concurrent observations during the 8:00 AM medication administration pass for Resident #1. There was a yellow sign with the letter EBP (Enhanced Barrier Precautions), which indicated the resident was on EBP, by the resident's name on the wall outside by the doorway.</p> <p>On 09/18/2024 at 8:59 AM, LPN #6 entered Resident #1's room to administer the resident's 8 AM medications. After changing a patch on the resident's left arm, LPN #6 picked up the PEG tube, connected a 60 cubic centimeter (cc) syringe, without the plunger, to the opening of the PEG tube and poured 60 milliliters (ml) of water in the tube and then unclamped it and allowed the water to flow by gravity. She administered the medications mixed in a cup of water, followed by 60 cc of water and then clamped the PEG tube. She did not check the tube for placement before giving the water or medications. She discarded the used gloves and items and sanitized her hands.</p> <p>On 09/18/2024 at 9:11 AM, LPN #6 was asked when she checked the resident's PEG tube placement for placement, and she stated before she administered the resident's medications. She was asked how she checked the resident's PEG tube for placement before giving the medications and she stated when she flushed the tube with water, and it flushed normally that was when she checked it. She was asked how she had been instructed to check the PEG tube for placement at the facility and she stated, Not necessarily to check for placement, but to flush the peg tube prior to and post medication administration.</p> <p>A review of Resident #1's medical diagnosis screen was reviewed and indicated the resident had a diagnosis of swallowing difficulties (dysphagia) and an opening in the stomach (gastrostomy status).</p> <p>A quarterly Minimum Data Set with an Assessment Reference Date of 06/06/2024 was reviewed and indicated the resident had a Staff Assessment for Mental Status score of 3, which indicated severely impaired and a feeding tube.</p> <p>A review of Resident #1's Order Summary Report was reviewed and indicated to check the tube for proper placement before each feeding, flush, or medication administration and the order was dated 07/10/2024. EBP due to PEG -tube ordered on 05/22/24</p> <p>(continued on next page)</p>		

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<p>F 0693</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A plan of care, dated 07/30/2024, was reviewed and indicated the resident required tube feeding related to dysphagia (difficulty swallowing) and an intervention included check for tube placement and gastric contents / residual volume per facility protocol and record. EBP- the resident required enhanced barrier precautions due to gastrostomy (G) tube and an intervention included following enhanced barrier precautions when giving device care.</p> <p>A facility policy titled Care and Treatment of Feeding Tubes, created 06/2019 and provided by the Administrator on 09/18/2024, was reviewed and indicated the facility would utilize feeding tubes in accordance with current clinical standards of practice, with interventions to prevent complications to the extent possible. The policy indicated in accordance with the facility protocol, licensed nurses would check that the feeding tube was in the right location, such as the stomach, depending on the tube and tube placement would be verified before beginning a feeding and before administering medications. The policy did not indicate how the licensed nurses would check the feeding tube for placement</p> <p>On 09/18/2024, the Director of Nursing (DON) was interviewed and asked if she had any guidance on how to check the PEG tube for placement and she stated she would find out. She later stated she did not have anything else regarding the G-tube. She clarified and confirmed she did not have any information regarding how the nurses should check the PEG tube for placement.</p> <p>On 09/19/2024 at 9:34 AM, the DON was interviewed and asked if a skills check off was done with the nurses on checking for PEG tube placement and she stated, No. She was asked, To clarify, yesterday you stated you had not provided to the nurses at this facility any guidance on how the nurses should check the PEG tube for placement, and she confirmed she had not.</p> <p>A Facility Assessment, dated as approved 09/03/2024, and provided by the Administrator on 09/16/2024, was reviewed and indicated staff was trained on policies and procedures consistent with their roles and those policies and procedures required in the provision of care would be evaluated. The assessment indicated the Quality Assurance and Performance Improvement (QAPI) process would be used in the evaluation of the policies and if new or updated policies were needed, ensure the policies were developed or updated.</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>48977</p> <p>Based on record review, interviews, and facility policy review, the facility failed to ensure and provide pharmaceutical services which included accurate administration of all drugs and/or biologics to 1 (Resident #11) sampled resident.</p> <p>The findings include:</p> <p>1. A review of the Order Summary Report Resident #11 had an order for (Hydrocodone-Acetaminophen 5-325 mg), an opioid medication, as needed for pain.</p> <p>a. Review of a significant change Minimum Data Set (MDS) with the Assessment Reference Date (ARD) of 9/1/2024 revealed Resident #11 had a Brief Interview of Mental Status (BIMS) score of 4, indicating severe cognitive impairment. The MDS indicated Resident #11 was not taking an opioid medication.</p> <p>b. A plan of care for Resident #11 (revision date 9/06/2024) revealed Resident #11 had pain related to osteoarthritis (OA), and an intervention noted was administer pain medications as ordered/needed .notify medical doctor (MD)/Practitioner if not effective.</p> <p>c. A review of the Controlled Drug Record indicated Resident #11's opioid was signed by nursing staff as having been administered on 42 occasions between 09/03/24 and 09/17/24. There were only 14 instances of the medication being administered in Resident #11's noted on the resident's Medication Administration Record (MAR).</p> <p>d. On 09/18/24 at 11:25 AM, Licensed Practical Nurse (LPN) #9 stated the process for administering as needed controlled medications was check the MAR to see if it is time to give the medication, pull the medication, sign it out in the controlled drug book, and sign it off on the MAR. LPN #9 stated the electronic system used by the facility later asked if the medication was effective, but if the administration of the medication was not documented in the MAR the system does not know to ask about the effectiveness of the medication.</p> <p>e. On 09/18/24 at 11:30 AM, the Director of Nursing stated the process for administering an as needed controlled medication was administer the medication, check it off on the MAR, and document it in the controlled log. The DON stated all steps should be completed. The DON stated it was not noted on the significant change MDS Resident #11 was taking an opioid, and according to the MAR Resident #11 had not taken the medication during the look back period 8/18/2024-9/1/2024. The DON stated that information on the MAR was incorrect based on the controlled drug record.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045190	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/19/2024
NAME OF PROVIDER OR SUPPLIER Nightingale at Crossett		STREET ADDRESS, CITY, STATE, ZIP CODE 1101 Waterwell Road Crossett, AR 71635	
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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<p>F 0803</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident.</p> <p>03508</p> <p>Based on observation, record review, and interview, the facility failed to ensure meals were prepared and served according to the planned written menu to meet the nutritional needs of the residents for 1 of 2 meals observed. This failed practice had the potential to affect residents who received pureed diets and residents who had mechanical soft diets from 1 of 1 kitchen according to a list provided by the Dietary Service Manager.</p> <p>The findings are.</p> <ol style="list-style-type: none"> On 09/17/2024, a facility noon menu indicated the following: residents on regular diets were to receive 4 ounces of country ranch chicken, residents on pureed diets were to receive a #8 scoop (4 ounces) of pureed country ranch chicken, and residents on mechanical soft diets were to receive a # 8 scoop (4 ounces) of ground country ranch chicken, and one-half (1/2) cup of cauliflower. On 09/16/2024 at 12:52 PM, the following observations were made during the noon meal service. <ol style="list-style-type: none"> Dietary [NAME] (DC) #3 used a 3-ounce ladle to serve a single portion of mechanical soft country ranch chicken to the residents on mechanical soft diets, instead of a #8 scoop (4 ounce). DC #3 used a 3-ounce ladle one-third (1/3) cup to serve a single portion of cauliflower to the residents on mechanical soft diets, instead of 1/2 cup. DC #3 used a 3-ounce spoon to serve a single portion of pureed cauliflower to the residents on pureed diets, instead of a #8 scoop (1/2 cup). On 09/16/2024 at 1:06 PM, all residents on regular diets were served one small serving of country ranch chicken. On 09/16/2024 01:06 PM, all residents on regular diets were served one small serving of country ranch chicken. On 09/16/2024 at 1:09 PM, the Dietary Service Manager was asked to weigh the same amount of country ranch chicken served to the residents on regular diets. She stated the ranch chicken weighed 2.9 ounces. They should have given 2 pieces each. At 1:10 PM, DC #4 confirmed 2 pieces of chicken should have been served, instead of one piece of chicken. On 09/16/2024 at 1:15 PM, DC #3 was asked what size of spoon she used to serve mechanical soft meat, cauliflower and pureed cauliflower. DC #3 stated she used a 3-ounce spoon, serving a single portion of meat to each resident on mechanical soft diets. For cauliflower she used a 3-ounce spoon to serve a single portion of cauliflower to each resident on mechanical soft diets and a 3-ounce spoon to serve a single portion of pureed cauliflower to each resident on pureed diets. DC #3 stated we need more 4-ounce ladles, 		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 03508</p> <p>37925</p> <p>Based on observation, interview, record review and facility policy review, the facility failed to ensure expired food was removed from a resident's bedside cooler for 1 (Resident #9) of 1 sampled resident reviewed for bedside snacks; failed to ensure cake product stored in the freezer was not mushy and unpalatable, other foods were covered or sealed to decrease the potential for cross contamination; dietary staff thoroughly washed their hands and changed gloves when contaminated and before handling food and clean equipment to decrease the potential for food borne illness for residents receiving food from 1 of 1 kitchen; expired food items and spices were promptly removed/discarded on or before the expiration or use by date; hot food items were maintained at the required temperatures on the steam table to prevent potential food borne illness. These failed practices had the potential to affect residents who received meals from the kitchen (with a total census of 55), according to the list provided by the Dietary Service Manager.</p> <p>The findings are.</p> <ol style="list-style-type: none"> 1. On [DATE] at 9:40 AM, one angel food cake on a shelf in the freezer dated [DATE] was not frozen solid and was mushy to touch. The Dietary Service Manager stated it is soft, Dietary [NAME] (DC) #3 stated it was taken out of the freezer yesterday and was not used. 2. On [DATE] at 10:04 AM, the following observations were made in the freezer: <ol style="list-style-type: none"> a. An opened box of cobbler sheet dough was on a shelf. The box was not covered or sealed. b. An opened box of pepperoni was on a shelf. The box was not covered or sealed. c. An opened box of chicken fingers was on a shelf. The box was not covered or sealed. 3. On [DATE] at 10:08 AM, the following observations were made on a rack in the storage room: <ol style="list-style-type: none"> a. An opened container of parsley flakes with an expiration date of [DATE]. b. An opened bottle of rubber sage with an expiration date of [DATE]. c. Three boxes of breakfast drink mix with an expiration date of [DATE]. d. Two bags of corn chips one with an expiration date of [DATE] and one with an expiration date of [DATE]. e. Three bags of candy bars with an expiration date of [DATE]. 4. On [DATE] at 10:44 AM, a gallon of whole milk was on a shelf in the refrigerator with an expiration date of [DATE]. <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>5. On [DATE] at 10:45 AM, a box that contained 12 cartons of nutritional supplement was on a rack in the kitchen with an expiration date of [DATE].</p> <p>6. On [DATE] at 10:51 AM, an opened box of salt was in a pan under the food preparation counter. The box was not covered.</p> <p>7. On [DATE] at 11:20 AM, the bottom of the deep fryer had grease built up on it. The Dietary Service Manager was asked how often they cleaned it. DC #3 stated we clean it every two weeks. The Dietary Service Manager stated it doesn't look like it has been cleaned.</p> <p>8. On [DATE] at 11:30 AM, DC #4 removed a pitcher of tea from the refrigerator and placed it on the counter. Without washing her hands, she picked up glasses by the rims and placed the glasses on the trays. At 11:33 AM, DC #4 turned on the food preparation sink faucet and obtained water into the glasses. She then turned off the faucet, held the glasses by the rims and placed the glasses on the tray to be served to the residents for the noon meal.</p> <p>9. On [DATE] at 12:00 PM, DC #3 used a rag to wipe off spilled food crumbs from the counter. Without washing her hands, she picked up a clean blade and attached it to the base of the blender to be used in pureeing food items to be served to the residents for noon meal.</p> <p>10. On [DATE] at 12:04 PM, Dietary Aide (DA) #5 used a rag to wipe off spilled food crumbs from the counter. Without washing her hands, she picked up clean bowls to be used in portioning desserts to be served to the residents who required pureed diets for noon meal and placed them on the counter with her fingers inside the bowl. DA #5 was asked what she should she have done after touching dirty objects and before handling clean equipment. DA #5 stated she should have washed her hands.</p> <p>11. On [DATE] at 12:10 PM, the temperatures of the food items on the steam table in the kitchen were checked and read by DC #3 with the following results:</p> <p>a. Regular country ranch chicken 111 degrees Fahrenheit, Pureed bread with milk on the grill was 105 degrees Fahrenheit. The above food items were not reheated before being served to the residents.</p> <p>c. On [DATE] at 8:33 AM, DC #3 was asked what she should you have done when food items were not hot enough to be served to the residents, she stated I should have put it back on the grill.</p> <p>12. On [DATE] at 3:58 PM, DC #4 wore gloves on her hands when she picked up a spray bottle and sprayed inside a pan, contaminating the gloves. DC #4 then pulled out a drawer, removed a knife, and used it to cut 14 servings of corndogs in half. Using her gloved hands, she picked the corndogs and placed them into a blender. She ground the corndogs, poured the ground corndogs into a pan and placed the pan in the oven to be served to the residents on mechanical soft diets for supper meal.</p> <p>13. On [DATE] at 4:07 PM, DC #4 wore gloves on her hands when she turned on the food preparation sink faucet and obtained water into a pitcher, contaminating the gloves. Without changing gloves and washing her hands, DC #4 picked up a clean blade and attached it to the base of the blender to be used in pureeing meat for residents on pureed diets. At 4:10 PM, DC #4 placed 10 servings of corndogs into the blender with the contaminated blade, pureed the corndogs, poured the contents into a pan and placed the pan in the oven.</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>14. On [DATE] at 4:17 PM, DC #4 wore mittens on her hands when she removed a pan of macaroni and cheese from the oven and placed it on the counter. She removed mittens from her hands and placed them on the counter. Without washing her hands, DC #4 picked up a clean blade and attached it to the base of the blender to be used in pureeing food for residents on pureed diets. At 4:21 PM, DC #4 used a 4-ounce spoon to place 11 servings of macaroni and cheese into a blender with the contaminated blade, added warm milk, pureed the macaroni and cheese, poured the contents into a pan and placed the pan in the oven. At 4:32 PM, DC #4 was asked what she should have done when going from dirty and by handling clean equipment. She stated she should wash her hands.</p> <p>15. A facility policy titled, About Hand Washing not dated, and provided by the Dietary Manager indicated hands should be washed before, during and after preparing food.</p> <p>16. On [DATE] at 11:11 AM, Resident #9 was sitting up in high-back wheelchair with a device on the left wrist. There was a cooler on the nightstand with a four (4) ounce (oz) container of vanilla pudding and a container of non-fat yogurt.</p> <p>On [DATE] at 11:15 AM, Certified Nursing Assistant (CNA) #1 was interviewed and with concurrent observations and she was asked who was responsible for placing food items in Resident #9's cooler. She stated the transportation aide puts the contents in the cooler every morning and the CNAs on the second (2nd) and third (3rd) shift. She stated the items in the cooler were changed out each shift. She was asked to look at the yogurt and state the expiration date indicated on the bottom of the container, and she stated, [DATE].</p> <p>Resident #9's Order Summary Report was reviewed and indicated the resident had a diagnosis of swallowing difficulties (dysphagia) and an order dated [DATE] for a high calorie diet of a pudding-like (pureed) texture.</p> <p>A quarterly Minimum Data Set with an Assessment Reference Date of [DATE], was reviewed and indicated Resident #9 had a Brief Interview of Mental Status score of 7, which indicated severely impaired and on a diet which the texture was changed (mechanically altered).</p> <p>Resident #9's plan of care, dated [DATE], was reviewed and indicated the resident could possibly have a decrease in nutrition related to a mechanically altered diet and required fortified foods.</p> <p>On [DATE] at 2:23 PM, CNA #2 was observed passing snacks from a cart to the residents. She was interviewed and asked where the snacks on the cart came from and she stated, The kitchen. She was asked if the yogurt came from the kitchen because there was no yogurt on the snack cart at that time and she confirmed the yogurt also came from the kitchen.</p> <p>A Diet, Sanitation, and Menu policy, not dated, and provided by the Administrator on [DATE] was reviewed and indicated the facility would store, prepare, distribute and serve food under sanitary conditions.</p>		

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<p>F 0838</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations and emergencies.</p> <p>37925</p> <p>Based on record review and interview, the facility failed to ensure the facility assessment included pertinent information to assure the necessary care and resources were allocated to meet the needs of the residents in 1 of 1 facility. This deficient practice had the potential to affect all residents of the facility</p> <p>The findings are:</p> <p>A review of the Facility Assessment, dated as approved 09/03/2024 and reviewed by the Quality Assurance and Assessment (QAA) committee on 09/05/2024, did not contain the following required information:</p> <p>a. Documentation of the member of the governing body responsible for the completion of the assessment. No name was listed to indicate who the governing body member was.</p> <p>b. Addressed the staffing needs of each resident unit to ensure coordination and continuity of care. The facility has an East, West, and Secure Unit and the assessment only addressed the East unit staffing needs.</p> <p>c. Staff training/education and competency-based skill set approach to make informed staffing decisions to ensure residents are able to maintain or attain their highest practicable physical, functional, mental, and psychosocial well-being and meet current professional standards of practice as identified through the resident assessment and plans of care.</p> <p>d. Health information technology resources for managing resident records and sharing information with other organizations, the implementation of downtime procedures and how residents / resident representatives can access their records upon request and obtain copies within required timeframes.</p> <p>e. Food and Nutrition services staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, taking in consideration resident assessments, individual plans of care and the number, acuity, and diagnoses of the facility's resident population.</p> <p>On 09/19/2024 at 1:28 PM, the Administrator was interviewed and asked who was responsible for completing the Facility Assessment and she stated it was a group effort, but she mainly did it. She was asked who reviewed the policies and procedures regarding the resident care needs, and she stated it was a group effort, including her, and the nurse consultant. She was asked when the review of the policies and procedures occurred, and she stated yearly. She was asked who the governing body member was who assisted with the completion of the facility assessment due to name was listed, and she stated she guessed it was the Regional Director of Operations (RDO). She was asked why there were no signatures for the Medical Director or the governing body member on the page titled persons responsible for completion of assessment. She stated neither had reviewed the assessment yet. The Administrator was asked if the Medical Director was a part of the QAA committee and she stated he was, but he did not attend every meeting.</p> <p>(continued on next page)</p>		

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<p>F 0838</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>The Purpose Statement on the Facility Assessment indicated the assessment was to determine what resources were necessary to care for the residents competently during the day-to-day operations (including nights and weekends) and emergencies. The Facility Assessment indicated the responsibility of completing the assessment involved active involvement of nursing home leadership and management, including but not limited to a member of the governing body, the medical director, an administrator and the director of nursing.</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p>37925</p> <p>48977</p> <p>Based on observation, record review, interview and facility policy review, the facility failed to ensure staff followed Enhanced Barrier Precautions(EBP) for a resident with a Percutaneous Endoscopic Gastrostomy (PEG) tube (a feeding tube inserted through the belly and into the stomach) for 1 (Resident #1) of 1 sampled resident reviewed for enhanced barrier precautions and failed to ensure that 1 sampled (Resident #25) resident received proper incontinence care.</p> <p>The findings are:</p> <p>On 09/18/2024 at 8:29 AM, Licensed Practical Nurse (LPN) #6 was interviewed with concurrent observations during the 8:00 AM medication administration pass for Resident #1. At 8:59 AM, LPN #6 entered Resident #1's room to administer Resident's 8 AM medications. Once the medications and other items were on the bedside table, she raised the resident's bed up higher. She put on a clean pair of gloves but did not put on a gown. After changing a patch on the resident's left arm, LPN #6 picked up the PEG tube, connected a 60 cubic centimeter (cc) syringe, without the plunger, to the opening of the PEG tube and poured 60 milliliters (ml) of water in the tube and then unclamped it and allowed the water to flow by gravity. She administered the medications mixed in a cup of water through the tube, followed by 60 cc of water and clamped the PEG tube. She discarded the used gloves and items and sanitized her hands.</p> <p>On 09/18/2024 at 9:11 AM, LPN #6 was asked when a resident was on EBP, when was personal protective equipment (PPE) put on and she stated always and before you enter the room. She was asked what PPE was required for EBP and she stated a gown, gloves and mask. She was asked if she put on a gown prior to administering the resident's medications through the PEG tube and she confirmed she did not, and the resident was not on EBP. She was asked to look at the resident's physician's orders and check if the resident had an order for EBP. She looked at the orders in the resident's electronic health record and stated, She does. She was asked to look at the resident's name by the door to see if there was an EBP sign in place and she confirmed it was.</p> <p>A review of Resident #1's medical diagnosis screen was reviewed and indicated the resident had diagnoses of swallowing difficulties (dysphagia) and an opening in the stomach (gastrostomy status).</p> <p>A quarterly Minimum Data Set with an Assessment Reference Date of 06/06/2024 was reviewed and indicated the resident had a Staff Assessment for Mental Status score of 3, which indicated severely impaired and a feeding tube.</p> <p>A review of Resident #1's Order Summary Report was reviewed and indicated enhanced barrier precautions due to a gastrostomy tube (G-tube) and was ordered on 05/22/2024.</p> <p>A plan of care, dated 07/30/2024, was reviewed and indicated the resident required enhanced barrier precautions due to a G tube and an intervention included following EBP when giving device care and signage use to identify residents.</p> <p>(continued on next page)</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>An Enhanced Barrier Precautions policy, dated March 2024, was reviewed and indicated EBPs were used as an infection prevention and control intervention to reduce the spread of multi-drug-resistant organisms to residents. The policy indicated gown and glove usage during high contact resident care activity, such as device care or use and an example was a feeding tube.</p> <p>According to the Annual Minimum Data Set (MDS) with the Assessment Reference Date (ARD) of 8/30/2024 revealed Resident #25 scored 04 on the Brief Interview of Mental Status indicating severe impaired cognition and was frequently incontinent of bowel and bladder.</p> <p>A plan of care for Resident #25 (revision date 3/07/2024) revealed Resident #25 had frequent bladder and bowels incontinence related to Alzheimer's and required staff to clean peri-area with each incontinence episode.</p> <p>On 09/18/24 at 09:15 AM, the Surveyor observed Certified Nursing Assistant (CNA) #7 performing incontinence care to Resident #25, but did not clean the genital area.</p> <p>On 09/18/24 at 09:16 AM, CNA #7 stated I know I did wrong and that she did not clean the front of the resident.</p> <p>On 09/18/24 at 11:30 AM, the Director of Nursing (DON) stated when staff are providing incontinence care to a resident , they should clean the genital area to prevent infection, maintain the dignity of the resident, and promote cleanliness.</p> <p>A policy titled Perineal Care instructed staff to promote cleanliness and prevent infection by removing irritating and odorous secretions, to prevent extended skin exposure to incontinence of urine/feces, and to clean the resident's genital area properly.</p>