STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045194	A. Building B. Wing	01/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Cottages at Texarkana	4701 Jefferson Avenue Texarkana, AR 71854

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 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. 46724 Based on observation, interview, and record review, the facility failed to ensure a resident was transferred in a safe manner to prevent injury for one (Resident #1) of two (Resident #1 and Resident #2) sampled residents. The findings are: Review of Resident #1's diagnosis sheet indicated diagnoses that included paraplegia (paralysis that affects the lower body), osteoarthritis, anxiety, fracture of the right patella (kneecap), and effusion (fluid around knee joint). Resident #1's quarterly Minimum Data Set (MDS) with an assessment reference date (ARD) of 1/13/2025 indicated a brief interview of mental status (BIMS) score of 15 (cognitive), had no behaviors, ambulated via wheelchair, received maximal assistance with bed mobility, was dependent transfers and received scheduled and as needed pain medication for pain rated at an 8/10. Review of Resident #1's physician's orders dated 01/09/2024 indicated to monitor the skin on the right patella and bilateral heels, use fall precautions, ensure knee immobilizer to right knee had a snug fit and ensure immobilizer was utilized during weight bearing transfers. Review of Resident #1's care plan with a revision date of 11/25/2024 indicated the resident required 1-person assist with transfers and was at risk for falls. Review of Resident #1's progress notes for 12/18/2024 at 1:45 PM indicated certified nursing assistant (CNA) #2, reported that during a transfer to wheelchair, the resident's right foot had gotten caught in a wheel of the wheelchair. On the same day at 5:57 PM Licensed Practical Nurse (LPN) #6 documented that after resident #1 returned from a dental appointment the resident reported pain in their right knee. X-rays by a mobile x-ray company later that evening revealed a right patella fracture and effusion. (continued on next page)

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

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 01/22/2025 at 11:25 AM, while speaking with Resident #1, the resident explained, on the day of injury, CNA #2 and CNA #3 were assisting Resident #1 to get ready and up in the wheelchair for a dental appointment. Resident #1 explained the wheelchair arm raised to enable [pronoun] to slide from the bed to the wheelchair. Resident #1 went on to say CNA #2 did not position the wheelchair beside the bed correctly and while attempting to assist the resident from the bed to the wheelchair the resident's right foot became caught in the wheelchair wheel. Resident #1 said CNA #2 was in a hurry and tried to get [pronoun] transferred to the wheelchair. Resident #1 said [pronoun] told the CNAs [pronoun] foot was caught but they transferred anyway, and the resident heard a pop and felt pain in their right knee immediately. Resident #1 went on to say [pronoun] did not want to miss the dental appointment because sometimes the dentist would not reschedule if the appointment was missed. Resident #1 went to the appointment with [pronoun] knee hurting. When asked if the knee had been assessed prior to leaving for the appointment Resident #1 said that it had not. Resident #1 stated x-rays were ordered when [pronoun] returned and after the results the resident was sent to the emergency room . Resident #1 denied being afraid of any staff member. On 01/22/2025 at 11:32 AM CNA #2 said she and CNA #3 were getting Resident #1 ready for a dental appointment. CNA #2 stated she was not familiar with Resident #1 and had discussed with CNA #3 getting the patient lift to transfer the resident. Resident #1 had told her [pronoun] transferred directly to the wheelchair from the bed and did not use the lift. While attempting to assist Resident #1 to the wheelchair from the left side of the bed, the resident's right foot had gotten caught in the right wheel causing the resident's leg to twist during the transfer and the resident said their right knee hurt as a result. CNA #2 said she immediately went and told the nurse, LPN #6. On 01/22/2025 at 11:55 AM Transport/Restorative CNA #12 said Resident #1's knee was hurting on the day of the incident, but the resident wanted to go ahead to the dental appointment. He also stated, CNA #2 had already informed the nurse (LPN # 6) about the incident prior to them leaving. On 01/22/2025 at 2:45 PM the Administrator stated the previous Director of Nursing (DON) (who was no longer employed at the facility) had in-serviced the workers of Cottage 5 on accessing the care plan and proper transfers on 12/18/2024. The Administrator was asked to provide employee files with staff competencies. She was unable to locate then at that time. The current Director of Nursing (DON) was called to the Administrators office at that time. She related the staff competencies were kept in a binder that was located in a different cottage. On 01/22/2025 at 4:00 PM the Administrator informed this surveyor they were unable to locate the competencies, and the current DON had contacted the previous DON to try to locate them and had been told by the previous DON, she had shredded them due to being incorrect.

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. 46724 Based on observation, interview, and record review the facility failed to ensure ongoing staff training, competencies, and evaluations for all nursing staff. The findings are: On 01/22/2025 at 11:32 AM Certified Nursing Assistant (CNA) #2 said on 12/18/2024, she and CNA #3 were getting Resident #1 ready for a dental appointment. CNA #2 stated she was not familiar with Resident #1, was not sure of the method of transfer, and this was her first time working with the resident. While attempting to assist Resident #1 to the wheelchair from the left side of the bed, the resident's right foot had gotten caught in the right wheel causing the resident's leg to twist during the transfer and the resident said their right knee hurt as a result. CNA #2 said she immediately went and told Licensed Practical Nurse (LPN) #6. On 01/22/2025 at 11:55 AM Transport/Restorative CNA #12 said Resident #1 indicated [pronoun] knee was hurting on the day of the incident, but Resident #1 wanted to go ahead to the dental appointment. CNA #12 continued; CNA #2 had already informed the nurse (LPN #6) about the incident prior to them leaving. Review of Resident #1's progress notes for 12/18/2024 did not show an entry from LPN #6 indicating an assessment until after Resident #1 returned from their appointment with pain and swelling to the right knee. Resident #1 was sent to the emergency room and was diagnosed with a fractured right patella and right knee effusion (fluid around knee joint). On 01/22/2025 at 2:45 PM, while speaking with the Administrator concerning Resident #1and what had been done after the incident, the Administrator provided an in-service dated 12/18/2024, by the previous Director of Nursing (DON), that educated staff regarding use of the care plan and resident transfers to the staff of Cottage 5. On 01/22/2025 at 3:00 PM the DON and Administrator were asked for the employee files with competencies for: CNA #2, CNA #3, CNA #4, CNA #5, and CNA #12. The DON stated at that time the competencies were kept in a binder and were located in a different building. On 01/22/2025 at 4:00 PM the Administrator came to this surveyor and said since the last DON had recently quit, they had looked in her old office for the competencies and had been unable to locate them. The present DON had contacted the last DON who told her she had shredded them because they were the wrong ones. On 01/23/2025 at 8:05 AM via telephone interview, LPN #6 said she had assessed R #1prior to the resident leaving for the dental appointment on 12/18/2024. No documentation was found in Resident #1's electronic health record. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 01/22/2025 between 4:26 PM and 4:41 PM CNA # 8, CNA #9, CNA #10, and CNA #11 were asked if they had been trained and checked off on competencies prior to working with the residents. They all answered no.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 46724 Based on observation, interview, and facility policy review, the facility failed to ensure medications were kept secure to prevent unauthorized access in Cottages 2, 2A, 3, 4 and 5. The findings are: On 01/21/2025 in Secure Cottages 2 and 2A, it was observed between 10:28 AM and 11:16 AM in rooms 1,3, 7,10, 12, 12,5-A, and 9-A the medication storage area, which consisted of shelves with a lockable door, were unlocked allowing access to the medications inside by unauthorized people, including residents. Among the medications observed were medications for high blood pressure, thyroid medication, angina (chest pain) medication, anti-nausea medication, antiplatelets, cholesterol medication, anti-seizure medication, anti-depressants, drugs to treat Alzheimer's disease, drugs used to treat esophageal reflux, a vasodilator (used to increase blood flow), potassium stool softeners, and wound washes. On 01/21/2025 in Cottage 3 between 11:30 AM and 11:36 AM unlocked medication cabinets were observed which contained bronchodilators (medications use to open airways to allow easier breathing) and eye drops in rooms 1, 2, 3, and 4. On 01/21/2025 in Cottage 4 between 11:49 AM and 12:02 PM, in rooms 1, 4, 5, 7, and 12, unlocked medication cabinets were observed containing bronchodilators, opiate antagonists (medications that block opioids), anti-convulsant, antidepressants, cholesterol medication, antinausea medication, a bottle of anti-reflux medication, a tube of antifungal, a tube of antibiotic ointment, and an unlabeled bottle containing round white pills stored in a plastic zip closure storage bag. On 01/22/2025 at 4:20 PM an unlocked medication cart was observed in the living room area of Cottage 5 with no authorized personnel within eyesight. Three residents were sitting in the living room area. On 01/22/2025 at 11:20 AM this surveyor spoke with Licensed Practical Nurse (LPN) #1 who had worked at the facility for 3 years. When asked what type of residents she cared for in cottages 2 and 2-A, which were secure cottages, she stated a mixture of residents who were cognitive and residents who had cognitive impairments. She confirmed medications were kept locked up to keep them out of reach of residents who may take them but don't need them, and it could cause a serious outcome. She went on to say they were locked due to state law. When asked why some medication storage cabinets in the rooms which contained medications were unlocked, she responded, I don't use the cabinets, night shift uses the ones in the rooms, mine are on the medication cart. On 01/21/2025 at 3:37 PM the Director of Nursing (DON), who had only been in the roll of DON for five (5) days, was asked why medications were kept locked and secure. She responded that they were kept locked to prevent unauthorized access, which could lead to an overdose and lot of different issues. She confirmed they should be kept locked anywhere around the elders (residents). (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 01/22/2025 at 4:21 PM Certified Nursing Assistant (CNA)/Medication Technician #7 for Cottage 5 confirmed the medication cart should be kept locked when not in direct eyesight to prevent the residents from accessing it. Review of the facility's policy for Medication Storage, with a revision date of January 2018, indicated that medications were kept secure and only accessible to licensed nursing personnel, pharmacy personnel or staff members lawfully authorized to administer medications. Medication storage areas are to be kept locked except when being accessed by an authorized person.