

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045239	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/24/2024
NAME OF PROVIDER OR SUPPLIER Belle View Estates Rehabilitation and Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1052 Old Warren Road 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)
<p>F 0622</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Not transfer or discharge a resident without an adequate reason; and must provide documentation and convey specific information when a resident is transferred or discharged.</p> <p>48977</p> <p>Based on record review, interview, and facility policy review, the facility failed to ensure residents and/or resident representatives received a 30-day notice of discharge prior to being discharged /transferred from the facility for 3 (Residents #1, #2 and #3) sampled residents who were discharged and transferred to another facility.</p> <p>The findings are:</p> <p>1. Review of the quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 02/27/2024 revealed a Brief Interview for Mental Status (BIMS) score of 12, indicating moderately impaired cognition, and Resident #1 had a diagnoses of anxiety disorder, bipolar disorder, and Alzheimer's disease.</p> <p>Review of the plan of care for Resident #1 (revision date 09/12/2021) revealed Resident #1 had anxiety, depression and unspecified bipolar disorder due to major neurocognitive disorder due to Alzheimer's. The approach for the problem noted was to observe for occurrences of target behavior symptoms (specifically: pacing, wandering, disrobing, inappropriate response to verbal communication, violence/aggression towards staff/others, etcetera.) and notify the Medical Doctor (MD) as needed.</p> <p>Review of the form titled, DC [Discharge] Instructions & [and] Summary for Continued Care, Resident #1 was discharged from the facility on 05/07/2024 at 3:00 PM.</p> <p>Review of a letter titled, Immediate Discharge Notice dated 5/07/2024 emailed at 2:46 PM noted, I sincerely regret to inform you that a decision has been made to discharge your mother [Resident #1], from [the facility] effective immediately. [Resident #1] is being discharged due to concerns for her and others', safety related to exit-seeking behaviors, for which the facility is unable to meet her needs .</p> <p>On 09/23/2024 at 3:11 pm, during an interview, Certified Nursing Assistant (CNA) #2 stated she had cared for Resident #1 and the resident was independent and only required verbal cues. CNA #2 stated she had not observed Resident #1 trying to get out of the facility or heard the resident speaking of leaving the facility. CNA #2 stated Resident #1 would sometimes want to follow the smoker out, but the resident was compliant with redirection from staff.</p> <p>(continued on next page)</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 0622</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 09/23/2024 at 3:15 pm, during an interview, CNA #3 stated she had not observed Resident #1 trying to get out of the facility or heard the resident speaking of leaving the facility.</p> <p>On 09/23/2024 at 3:48 pm, during an interview, the Assistant Director of Nursing (ADON) stated there was a resident currently residing in the facility that was considered an elopement risk with an electronic wander management device in place due to trying to exit the facility, and at times successful. The ADON stated the door alarms sound when a resident exits or a resident with an electronic wander management device is near. The ADON stated Resident #1 was exiting seeking, combative when redirected, and it was becoming more frequent. The ADON stated there was no documentation that Resident #1 was frequently exit seeking. The ADON stated the facility's process for dealing with behavior was to rule out illness with diagnostic testing and contact the family to see if they could come up and help. The ADON stated labs were drawn to rule out illness, but nothing was documented or scanned into the residents' medical records. The ADON stated she could not prove through documentation that the family was notified prior to the resident's discharge of the resident's exit seeking.</p> <p>On 09/24/2024 at 11:55 am, during an interview the Administrator stated the letter titled Immediate Discharge Notice was emailed and mailed to the family. The Administrator stated that if a resident was a harm to self or others the resident could not remain in the facility during the appeal process. The Administrator stated Resident #1 was not potentially harmful to others only considered harmful to self, because the resident was considered an elopement risk with the protentional to get out in the highway. The Administrator stated Resident #1 was discharged due to trying to leave the facility. The decision to discharge the resident was made that morning after a discussion with our attorney before knowing the resident had removed the wander guard. The Administrator stated she was unsure if the resident was informed of the transfer. The Administrator stated the day before discharge was the only day to her knowledge Resident #1 had attempted or exited the facility. The Administrator stated the only interventions the facility had put in place to attempt to meet the resident's needs was the electronic wander management device. The Administrator stated the facility did not consult with the resident's medical physician, psychiatric physician, or other medical professionals for assistance with meeting the resident's needs. The Administrator stated the resident needed to be on a secure unit not geriatric psychiatry, because the resident would get medicated then returned to the facility.</p> <p>On 09/24/2024 at 4:00 pm, during an interview, Licensed Practical Nurse (LPN) #1 stated he was coming from the kitchen and observed Resident #1 exiting the door behind her daughter. LPN #1 said the resident walked to the flower bed just outside the door and started playing with the flowers. LPN #1 stated Resident #1 did not attempt to walk past the flower bed and was not told to stop.</p> <p>Review of a policy titled, Admission, Transfer, & [and] Discharge noted, .Timing of notice of discharge. The notice will be made at least 30 days before the Resident/Elder is discharged unless: 1. The safety of individuals in the nursing facility would be endangered; 2. The health of individuals in the nursing facility would be endangered; 3. The Resident/Elder's health improves to allow a more immediate transfer or discharge; 4. A discharge is required by the Resident/Elder's urgent medical needs; or 5. The Resident/Elder has not resided in the facility for 30 days. In the above situations, notice will be made as soon as practical before the transfer or discharge .</p> <p>37925</p> <p>(continued on next page)</p>		

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<p>F 0622</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>2. Resident #3's, Admission Nursing Evaluation form, dated 06/20/2024, was reviewed and indicated the resident was admitted from a hospital and had poor decision-making skills and poor safety awareness.</p> <p>Resident #3's Order Summary Report was reviewed and indicated the resident had a diagnosis of poor decision-making skills (dementia).</p> <p>An admission MDS with an ARD of 06/25/2024 was reviewed and indicated the resident had a Brief Interview for Mental Status (BIMS) score of 9, which indicated the resident was moderately cognitively impaired.</p> <p>Resident #3's care plan, dated 06/25/2024, was reviewed and indicated the resident had impaired cognitive function related to dementia, poor decision-making skills and poor safety awareness and staff were to cue, reorientate, and supervise, the resident as needed.</p> <p>Resident #3's, Admission Summary, dated 06/20/2024 at 11:34 (AM) was reviewed and indicated the resident's initial goal for discharge was to remain in the facility for long term care.</p> <p>Resident #3's, Social Service History/Assessment, dated 07/03/2024 was reviewed and indicated for discharge planning, the resident was to remain in the facility for long term care after rehabilitation.</p> <p>A Wandering Risk Scale dated 07/04/2024 was reviewed and indicated the resident scored 16, (11 and above indicates high risk to wander) and a wander guard was placed on the resident.</p> <p>Resident #3's Behavior Note dated 07/24/2024 at 18:52 (6:52 PM) was reviewed and indicated the resident was pushing on an exit door, setting the alarm off and was yelling, crying, cursing and swinging at staff. Staff attempted to redirect the resident, the resident was medicated with 0.5 milligrams (mg) of a sedative, and the resident calmed down.</p> <p>Resident #3's Nursing Note dated 08/07/2024 at 17:09 (5:09 PM), was reviewed and indicated the resident was pushing on an exit door, hitting, yelling and cursing staff and was redirected and the family was called.</p> <p>Resident #3's, Nursing Note, dated 08/08/2024 at 13:43 (1:43 PM) was reviewed and indicated the resident was discharged to another facility with medications, personal belongings and was transported by the facility van with staff.</p> <p>Resident #3's progress notes dated 06/20/2024 to 08/08/2024 were reviewed and did not indicate the resident or the resident's family member received a 30-day discharge notice.</p> <p>Resident #3's Notice of Transfer/Discharge/LOA [Leave of Absence] with Bed Hold Policy, dated 08/08/2024, was reviewed and indicated the transfer or discharge was necessary and the reason for the transfer-discharge was attempting to go out exit doors.</p> <p>(continued on next page)</p>		

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<p>F 0622</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 09/24/2024 at 3:53 PM, the Director of Nursing (DON) was interviewed and asked when the decision was made to discharge Resident #3. She stated the resident's transfer was discussed and decided the next morning, 08/08/2024, which is the day the resident was discharged /transferred from the facility. She was asked who notified the family of the decision to discharge the resident. She stated the Social Service Director (SSD) called the family on the day of the resident's discharge/transfer.</p> <p>On 09/24/2024 at 4:04 PM, the SSD was interviewed and asked when she was notified of the decision to discharge/transfer Resident #3 and she stated in the morning meeting (08/08/2024). She was asked if she notified the resident's family, and she confirmed she called the family the morning of the discharge/transfer (08/08/2024). She was asked who notified the resident of the discharge/transfer decision and she stated she spoke to the resident the day of the discharge/transfer.</p> <p>48390</p> <p>3. A review of the Admission Record, indicated Resident #2 had diagnoses that included a personal history of transient ischemic attack (TIA), and cerebral infraction without residual deficits, memory deficit following cerebral infraction, disorientation, unspecified, other chronic pain.</p> <p>A review of the Immediate Discharge Notice dated 05/17/24, indicated Resident #2 was transferred to another health facility as stated, .discharged due to concerns for her, and others', safety .</p> <p>A review of Progress Notes dated 05/12/24 at 5:15 PM, indicated Resident #2 going to multiple exits and voicing wanting to go outside, trying to open doors. Resident #2 was unable to be redirected due to agitation.</p> <p>A review of Progress Notes dated 05/17/24 at 7:15 AM, indicated Resident #2 was outside with staff. Staff reported the resident was exit seeking yesterday afternoon to all exit doors and again this AM. Will seek advice on placement of resident.</p> <p>A review of Progress Notes dated 05/17/24 at 9:00 AM, indicated Interdisciplinary Team met and agreed resident's best interest for safety was placement in a secure unit at another facility.</p> <p>During a phone interview on 09/23/34 at 3:40 PM, Resident #2's representative, indicated she received a phone call on 05/17/24 at 9:00 AM from the Director of Nursing (DON) and the DON advised her that Resident #2 was an exit seeker and was a safety hazard and had to be discharged on that date. Resident #2's representative indicated that she did not receive any discharge paperwork or anything to appeal the discharge. Resident #2's representative indicated that the only thing she received was the personal belongings that she packed up and the resident's medication. Resident #2's representative was asked if she ever received a 30 day notice of discharge. Resident #2's representative indicated that the only thing she received was a phone call telling her Resident #2 had to be discharged that day.</p> <p>During an interview on 09/24/24 at 10:55 AM, the Director of Nursing (DON) indicated that on 05/17/24, lawyers for the facility completed an immediate discharge for safety due to the resident trying to get out. The DON indicated they have a sister facility that had a resident get out and it cost them over \$60,000.00. The DON indicated they can't have a resident get out, not even one.</p> <p>(continued on next page)</p>		

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<p>F 0623</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights.</p> <p>37925</p> <p>Based on record review and interview, the facility did not ensure the transfer/discharge notice provided to the resident/resident representative included the required contents for 1 (Resident #3) of 3 (Residents #1, #2, and #3) sampled residents reviewed for discharge notice requirements.</p> <p>The findings are:</p> <p>Resident #3's, Admission Nursing Evaluation, dated 06/20/2024 was reviewed and indicated the resident was admitted from a hospital and had poor decision-making skills and poor safety awareness.</p> <p>Resident #3's, Order Summary Report was reviewed and indicated the resident had a diagnosis of poor decision-making skills (dementia).</p> <p>An admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 06/25/2024 was reviewed and indicated the resident had a Brief Interview for Mental Status (BIMS) score of 9, which indicated the resident was moderately cognitively impaired.</p> <p>Resident #3's, care plan, dated 06/25/2024, was reviewed and indicated the resident had impaired cognitive function related to dementia, poor decision-making skills and poor safety awareness and staff were to cue, reorient and supervise the resident as needed.</p> <p>Resident #3's, Nursing Note, dated 08/08/2024 at 13:43 (1:43 PM) was reviewed and indicated the resident was discharged to another facility.</p> <p>Resident #3's, Notice of Transfer/Discharge/LOA [Leave of Absence] with Bed Hold Policy, dated 08/08/2024, was reviewed and did not include information on how to obtain an appeal form or assistance in completing the form and submitting the appeal hearing request.</p> <p>An Admission, Transfer, and Discharge policy, not dated and provided by the Administrator on 09/24/2024, was reviewed and indicated the contents of the notice should include information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request.</p>		