

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045268	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/19/2024
NAME OF PROVIDER OR SUPPLIER Van Buren Healthcare and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1404 North 28th Street Van Buren, AR 72956	
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 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>42016</p> <p>Based on interviews, record review, and facility policy review, it was determined the facility failed to ensure 1 (Resident #4) of 7 residents reviewed for accidents and hazards received adequate supervision to prevent the potential for accidents. Specifically, the facility failed to ensure Resident #4 was supervised to prevent the access and potential for ingestion of hand sanitizer, on the overbed table next to a cup of water in Resident #4's room.</p> <p>Findings included:</p> <p>A review of the Admission Record, indicated the facility admitted Resident #4 with diagnoses that included senile degeneration of the brain, benign neoplasm of prostate, unspecified dementia, and metabolic encephalopathy.</p> <p>The quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 07/14/2024 revealed Resident #4 had a Brief Interview for Mental Status (BIMS) score of 1 which indicated the resident had severe cognitive impairment. Resident #4's functional abilities indicated resident required set up and clean up assistance with eating and oral hygiene. Resident #4 utilized a manual wheelchair for ambulation and required partial to moderate assistance with ambulation.</p> <p>A review of Resident #4's care plan initiated on 10/11/2023, revealed the resident had a terminal prognosis, was a wanderer, and was at risk for behaviors that included being up at night, roaming hallways, and taking hand sanitizer back to Resident #4's assigned room. Interventions included removing items from Resident #4's room when discovered.</p> <p>A review of the Nursing Medication Administration Record (MAR), revealed Resident #4 had a device to monitor wandering, was receiving hospice care, and behaviors were being monitored.</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 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 09/16/2024 at 2:16 PM, a family member (Family Member #1) of Resident #4 stated, Resident #4 had a diagnosis of dementia and was concerned about finding a pump bottle of hand sanitizer, with the lid off, on Resident #4's over bed table. Family Member #1 stated there was also a clear plastic cup with a clear fluid in it, a regular sip or drink cup with a straw in it, and a lined cup (like a graduated medication cup) containing 4 to 5 sealed straws, napkins, and the pump lid from the sanitizer bottle on the overbed table. Family Member #1 stated they called another family member, (Family Member #2), who had been in the facility during breakfast, and Family Member #2 said there was no sanitizer in Resident #4's room at breakfast. Family member #1 said they asked an aide to come to Resident #4's room to remove the sanitizer, but Family Member # 1 could not recall who the aide was. Family Member #1 stated their concern was that Resident #4 would drink the open hand-sanitizer.</p> <p>A review of an Incident and Accident Report dated 09/06/2024 at 11:45 AM, revealed a statement given by Certified Nursing Assistant (CNA) #2 which indicated an opened sanitizer bottle was located next to a cup of water with a straw in Resident #4's room, and Family Member #1 t voiced concern Resident #4 had the opened sanitizer bottle next to a cup of water with a straw.</p> <p>A review of the Progress Notes revealed a Nurses Notes on 09/06/2024 at 1:42 PM which revealed staff reported that a family member said Resident #4 drank hand sanitizer. Resident #4 did not recall drinking hand sanitizer.</p> <p>A review of the Progress Notes revealed a Nurses Notes on 09/08/2024 at 10:14 PM, Resident #4 was observed roaming and removed a box of tissues from the nurse's station.</p> <p>A review of the in-services done with staff on 09/06/2024, included a facility policies titled, Abuse & Neglect, with a revision date of 08/10/2022, that indicated neglect is failing to provide services to avoid physical harm to a resident and an adverse event is or risk of an untoward, undesirable, and unanticipated event. Prevention, protection and response procedures of neglect included dementia management, a review of federal rules and regulations, ongoing resident assessment, care planning behaviors, and observation; and Storage of Supplies and Equipment, with a revised date of 04/2008, that indicated Hazardous/toxic materials must be properly stored.</p> <p>During an interview on 09/18/2024 at 4:24 PM, CNA #2 stated Resident #4's family member approached the nurse's desk and requested CNA #2 accompany the family member to Resident #4's room, worried Resident #4 opened a bottle of sanitizer and a cup next to the open sanitizer had water in it. Upon entry of Resident #4's room, CNA #2 stated she observed a cup containing water, a bottle of sanitizer, a cup containing unopened straws with the pump top of the sanitizer in it. CNA #2 described the hand sanitizer as one used by the facility, [brand name] brand with the pump on top. CNA #2 stated they were not sure if a staff member left the sanitizer in Resident #4's room and that Resident #4 was up at night and searched through items and may have taken the bottle of hand sanitizer from the nurse's medication cart. CNA #4 stated we have to keep an eye on him.</p> <p>During an interview on 09/18/2024 at 4:35 PM, the Director of Nursing (DON) stated she was notified of the family member's concern of hand sanitizer being in Resident #4's room and stated Resident #4 wanders the halls in evening and grabs things. Education was done with staff to keep things put up and out of reach of dementia residents due to the hazard it poses.</p>		