STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045304	A. Building B. Wing	07/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Beebe Retirement Center, Inc.	709 McAfee Lane Beebe, AR 72012

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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. 50505 Based on observations, interviews, record review, facility document review, and facility policy review, it was determined the facility failed to ensure residents who want to self-administrate medications were properly assessed and deemed appropriate to do so for 1 (Resident #6) resident reviewed for self-administration of medications. Findings include: A review of a facility policy titled, Self-Administration of Medications, revised December 2016, indicated, Residents have the right to self-administer medications if the interdisciplinary team has determined that it is clinically appropriate and safe for the resident to do so .2. In addition to general evaluation of decision-making capacity, the staff and practitioner will perform a more specific skill assessment . A review of the Admission Record, indicated the facility admitted Resident #6 with a diagnosis of cognitive communication deficit. The annual Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 03/04/2024 revealed Resident #6 had a Brief Interview for Mental Status (BIMS) score of 14, which indicated the resident was cognitively intact. A review of Resident 6's Care Plan with an initiated date of 03/03/2023 revealed Resident #6 has capacity to understand and make decisions regarding healthcare and does not have an Advance Directive/Advance Care Plan (living will)/Healthcare Agent/Healthcare Surrogate/Durable Power of Attorney or other identified healthcare decision-maker. Interventions included follow up with the physician for any needed orders related to resident care decisions. A review of the Order Summary Report, revealed Resident #6 did not have an order to self-administer medications; 1.) Fluticasone Propionate Nasal Suspension, one spray in both nostrils two times a day related to allergic rhinitis, and 2.) Symbicort Inhalation Aerosol, two puffs, inhale orally two times a day for wheezing. Wait one minute between puffs/rinse, spit after administration. A review of the Medication Administration Record, revealed Resident #6 had 1) Fluticasone Propionate nasal solution and 2) Symbicort Inhalation Aerosol signed off by the nurses as being administered by a nurse. (continued on next page)

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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Nursing Assessments revealed there was no self-administration of medication assessments completed for Resident #6. During an observation on 07/17/2024 at 8:24 AM, Registered Nurse (RN) #2 was in the process of administering morning medications. RN #2 handed Resident #6 the resident's Symbicort handheld inhaler without instructions given. Resident #6 took the inhaler, brought the inhaler to the resident's mouth, completed one puff then without waiting, (waited approximately five seconds), took a second puff. Resident #6 failed to rinse their mouth and spit after the inhaler was administered. RN #2 administered eye drops, then handed Resident #6 the Fluticasone Propionate spray, without instructions given. Resident #6 took the spray, inserted the tip of the spray bottle into her right nostril, sprayed two squirts, then moved to the left nostril and sprayed two squirts, then handed the spray back to RN #2. During an interview on 07/18/2024 at 12:19 PM, RN #2 was asked if residents were allowed to self-administer medications, RN #2 stated, if the resident has been assessed. During an interview on 07/18/2024 at 11:30 AM, the Director of Nursing (DON) stated for a resident to be able to self-administer medications, an assessment would need to be completed, but stated, We do not let the residents self-administer unless there are extenuating circumstances. The DON confirmed that if an inhaler is self-administered, the resident would need to know the side effects, know and understand the orders for the medications and the nurse to observe the resident who can self-administer, and that the resident waits one minute between puffs if more than one puff is ordered. She also confirmed that the same would be true for nasal sprays. She also confirmed there would need to be an order from the physician and self-administration would need to be care-planned. The DON confirmed that nurses store the medications for any resident who has been assessed and is able to self-administer medications. When asked if there was a policy regarding self-administering medications, the DON replied, It would be in nursing policy book and that the nurses had access to those policies.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. 50505 Based on observations, interviews, record review, facility document review, and facility policy review, it was determined the facility failed to accurately complete assessments for 2 (Residents #42 and #59) residents reviewed for accurate completion of the Minimum Data Set (MDS). Findings include: A review of a facility policy titled, Resident Assessment Instrument, revised September 2010, indicated, .1. The Interdisciplinary Assessment Team must use the MDS form currently mandated by Federal and State regulations to conduct the resident assessment. Other assessment forms may be used in addition to the MDS form. 2. The purpose of the assessment is to describe the resident's capability to perform life functions and to identify significant impairments in functional capacity. 3. Information derived from the comprehensive assessment helps the staff to plan care that allows the resident to reach his/her highest practicable level of functioning . 1. A review of the Admission Record indicated the facility admitted Resident #42 with a diagnosis of presence of cerebrospinal fluid drainage device. The quarterly MDS with an Assessment Reference Date (ARD) of 06/20/2024 revealed Resident #42 had Section N: O415 - High Risk Drug Classes: Use and Indication were marked indicating Resident #42 was not taking an anticoagulant but was taking an antiplatelet - The admission MDS with an ARD of 09/18/2023 indicated the resident was not taking an anticoagulant. A review of Resident #42's Care Plan, revealed a problem as evidenced by no teeth related to poor oral hygiene initiated 09/25/2023. Intervention was initiated 01/01/2024 to administer medication as ordered and to monitor for side effects. No care plan was noted that addressed cerebrospinal fluid drainage device or the anticoagulant, apixaban. A review of Medication Administration Record for June 2024, revealed Resident #42 had been administered Apixaban, 1 tablet by mouth two times a day related to presence of cerebrospinal fluid drainage device (order date 09/11/2023) from June 1, 2024, to June 30, 2024. A review of the Medication Administration Record for September 2023, revealed Resident #42 had been administered Apixaban 1 tablet by mouth two times a day related to presence of cerebrospinal fluid drainage device (order date 09/11/2023) from September 11, 2023, to September 30, 2023. 2. A review of the Admission Record, indicated the facility admitted Resident #59 with diagnoses that included encephalopathy (inflammation of the brain), acute embolism and thrombosis (blood clot) of deep veins of left upper extremity, dysphagia (difficulty swallowing), and gastrostomy status (feeding tube). The quarterly MDS with an ARD of 06/29/2024 revealed Resident #59 was marked in Section GG0115: functional limitation in range of motion was marked as 0 (no impairment) of upper extremity (shoulder, elbow, wrist, hand). Section N:0415 high-risk drug classes: use and indication were marked anticoagulant (is taking) with indication. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The annual MDS with an ARD of 03/29/2024 revealed Resident #59 was marked in Section GG0115: Functional Limitation in Range of Motion as 0 (no impairment). Section N:0415 High-Risk Drug Classes: Use and Indication: antiplatelet was marked (is taking) with indication. A review of Resident #59's Care Plan, revealed the resident was on anticoagulant therapy using apixaban related to deep vein thrombosis to arms initiated 07/01/2022. Interventions: Administer anticoagulant medications as ordered by physician. Monitor side effects and effectiveness every shift. Apixaban tablet black box warning: discontinuation, premature discontinuation of any oral anticoagulant, including apixaban, increases the risk of thrombotic events; daily skin inspection; Labs as ordered, report abnormal lab results to medical doctor; monitor/document/report PRN (as needed) adverse reactions of anticoagulant therapy. A review of Resident #59's Care Plan revealed the resident had an Activities of Daily Living self-care performance deficit related to generalized weakness, decreased mobility secondary to recent hospitalization for encephalopathy. (initiated 08/05/2022). Interventions included: Contractures: the resident has contracture left hand/arm with a deficit to his range of motion. Provide skin care to keep clean and prevent skin breakdown. Hand roll to left hand as tolerated. Resident removes at times. A review of Order Summary Report for Resident #59 revealed there was an order for Apixaban tablet one tablet by mouth two times a day related to acute embolism and thrombosis of deep veins of left upper extremity. Order date of 03/16/2023. A review of the Medication Administration Record, for March 2024 revealed Resident #59 was administered Apixaban 1 tablet by mouth two times a day related to acute embolism and thrombosis of deep veins of left upper extremity (order date 03/16/2023) from 03/01/2024 to 03/31/2024, with the exception of 3/26/2024 (4:00 PM, dose held), 03/27/2024 to 03/28/2024 (was held) and 03/29/2024 8:00 AM dose was held and restarted 03/29/2024 at 4:00 PM. A review of the Restorative Log for the week of 07/15/2024 to 07/21/2024, revealed Resident #59 was provided restorative services of active assistive range of motion to left upper extremity (including elbow, wrist, and all digits) three times a week. Hand roll/wash cloth was to be replaced at that time. Restorative services were to continue indefinitely. During an observation on 07/16/2024 at 8:32 AM, Resident #59 was lying supine in bed with the foot of bed slightly raised. Left hand lying along the side of the resident's body on top of the covers, hand roll noted in Resident #59's left hand. During an observation on 07/16/2024 at 1:17 PM, Resident #59 was being assisted with lunch by a certified nursing assistant and the hand roll was noted to be in the resident's left hand. During an interview on 07/17/2024 at 8:34 AM, Registered Nurse (RN) #2 confirmed that care plans and assessments were in the process of being updated and corrected. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 07/18/2024 at 11:30 AM, the Director of Nursing (DON) confirmed that the MDS Coordinator and the Medicare Manager are responsible for care planning and the MDS completion. The DON stated that both are new to their positions. When asked by the surveyor what process the nurses use to complete the MDS, the DON responded with, They follow the MDS questions. The DON was asked to review Resident #42's admission MDS with an ARD 09/18/2023, and the quarterly MDS with ARD of 06/20/2024. The DON confirmed Section N on each MDS was marked as an antiplatelet and not an anticoagulant. The DON agreed Apixaban is classified as an anticoagulant not antiplatelet. The DON confirmed Resident #59 had a left-hand contracture. After reviewing Resident #59's quarterly MDS with an ARD of 06/29/2024, the DON agreed that the MDS was marked wrong in Section GG0115 Functional limitation in Range of Motion (ROM) and Section N0415. The DON confirmed it was marked antiplatelet and not anticoagulant.

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F 0657 Level of Harm - Potential for minimal harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. 50505 Based on observations, interviews, record reviews, facility document reviews, and facility policy review, it was determined the facility failed to revise and update the care plan to reflect current tube feeding status for 1 resident (Resident #59) reviewed for care planning for tube feeding. Findings include: A review of a facility policy titled, Care Plan, Comprehensive Person-Centered revised December 2016, indicated, .13. Assessments of residents are ongoing and care plans are revised as information about the residents and the residents' conditions change . A review of the Admission Record indicated the facility admitted Resident #59 with diagnoses of dysphagia (difficulty swallowing) and gastrostomy status (feeding tube). The quarterly Minimum Data Set (MDS) with an Assessment Reference Date of 06/29/2024 revealed Resident #59's nutritional approaches while a resident, included a feeding tube, a mechanically altered diet, and a therapeutic diet. A review of Resident #59's Care Plan revealed Resident #59 had an activities of daily living (ADL) self-care performance deficit related to generalized weakness, decreased mobility secondary to recent hospitalization for encephalopathy (inflammation of the brain). Initiated 08/05/2022. Interventions included, eating receives nutrition and medications via peg tube. The diabetic formula at 60 milliliters (ml) per hour via tube feeding pump and the resident is totally dependent on one staff for eating. Resident #59 has a nutritional problem or potential for nutritional problem related to diabetes, gastroesophageal reflux disease, and need for enteral feeding (initiated 01/17/2024), interventions include: explain and reinforce to the resident the importance of maintaining the diet ordered. Encourage the resident to comply. Explain consequences of refusal, obesity and malnutrition risk factors; per resident's preference, meals will be served in room; provide and serve diet as ordered: regular enhanced, mechanical soft, regular consistency; encourage and assist with all meals. A review of the Order Summary Report, revealed Resident #59 had a diet order dated 01/19/2024 for a regular diet, mechanical soft texture, regular consistency, and an enteral feeding order three times a day related to gastrostomy status, give 237 ml of diabetic formula three time a day, dated 06/03/2024. A review of Medication Administration Record, for July 2024, revealed Resident #59 was receiving diabetic formula three times a day by feeding tube. During an observation on 07/15/2024 at 8:31 AM, Resident #59 was being assisted with eating, by a Certified Nursing Assistant (C.N.A.) sitting at the resident's bedside. During an observation on 07/16/2024 at 9:15 AM, Licensed Practical Nurse (LPN) # 1 administered diabetic formula 1.5, 237 ml via the feeding tube to Resident #59. (continued on next page)

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F 0657 Level of Harm - Potential for minimal harm Residents Affected - Some	During an observation on 07/16/2024 at 1:17 PM, Resident # 59 was being fed by a C.N.A. sitting in a chair at bedside. During an interview on 07/16/2024 at 9:20 AM, LPN #1 confirmed that Resident #59 received diabetic formula 1.5, one can (237 ml) three times a day and that Resident #59 also gets a regular mechanical soft tray for meals three times a day. During an interview on 07/18/2024 at 11:30 AM, the Director of Nursing (DON) confirmed that changes to the care plan should be made immediately or the next day during start up when orders are discussed. The DON confirmed that the long-term care MDS Coordinator and the Medicare Manager were new to their positions but that both had done MDS' for a while and were working on updating care plans.