| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 045317 | A. Building<br>B. Wing | 05/22/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Wood-Lawn Heights | 2800 Neeley Street<br>Batesville, AR 72501 |

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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
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| F 0623<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37526<br><br>Based on interviews, record review, it was determined the facility failed to notify the resident and the resident's representative in writing of a transfer to the hospital and failed to ensure the transfer notice had all required information regarding the transfer for 4 (Resident #31, Resident #26, Resident #85, and Resident #90) of 5 sampled resident reviewed for hospitalization .<br><br>Findings include:<br><br>A review of a facility policy titled, Transfer and Discharge (including AMA), implemented on01/2024, indicated, The facility's transfer/discharge notice will be provided to the resident and resident's representative in a language and manner in which they can understand. The notice will include all of the following at the time it is provided: a. The specific reason and basis for transfer and discharge. b. The effective date of transfer or discharge. c. The specific location .to which the resident is to be transferred or discharged . d. An explanation of the right to appeal the transfer or discharge to the State. e. The name, address (mailing and email) and telephone number of the State entity which receives such appeal hearing requests. f. information on how to obtain an appeal form. g. Information on obtaining assistance in completing and submitting the appeal hearing request. h. The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman.<br><br>1. A review of the Census tab within Resident #85's electronic health record indicated the resident was sent to the hospital three times from 01/10/2024 through 05/21/2024.<br><br>A review of a transfer letter for Resident #85 included the resident's representative name, date, resident #85's name, the location in which the resident was sent, the facility phone number, and Registered Nurse (RN) #7's name. No other information was listed on the document.<br><br>During an interview on 05/21/2024 at 6:05 PM, Resident #85's family member stated she had never received a letter from the facility stating the resident had been sent to the hospital and the facility only notified her by phone.<br><br>During an interview on 05/21/2024 at 10:53 PM, LPN #2 stated when a resident is sent to the hospital, she contacts the resident representative via phone and stated she had never sent a transfer letter before.<br><br>(continued on next page) |



| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| F 0623<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During an interview on 05/21/2024 at 11:16 PM, LPN #3 stated when a resident is sent to the hospital, she contacts the resident representative via phone and the facility was not required to send out a transfer letter.<br><br>During an interview on 05/22/2024 at 7:32 AM, LPN #6 stated when a resident is sent to the hospital, she contacts the resident representative via phone and has never sent out a transfer letter.<br><br>During an interview on 05/22/2024 at 8:12 AM, RN #7 stated when a resident is sent to the hospital, she completes a transfer letter that is given to the MDS Coordinator. RN #7 stated the MDS Coordinator then mailed the letter to the resident's representative.<br><br>During an interview on 05/22/2024 at 9:06 AM, LPN #8 stated when a resident is sent to the hospital, the nursing staff calls the family to notify them of the transfer and completes a transfer letter that is given to the MDS Coordinator. LPN #8 stated she did not know what the MDS Coordinator did with the letters but LPN #8 did not mail the letter.<br><br>During an interview on 05/22/2024 at 1:07 PM, the MDS Coordinator stated when a resident is sent out to the hospital, she receives a copy of the transfer letter from the nursing staff but did not mail anything to the resident's responsible party.<br><br>During an interview on 05/22/2024 at 2:12 PM, the DON stated the hall nursing supervisors were responsible for completing the hospital transfer letters and mailing them to the resident's responsible party, then the supervisor provides the MDS Coordinator with a copy. The DON stated the only information provided on the transfer letter was the date the resident was sent out, where they were sent, and the reason for the transfer.<br><br>During an interview on 05/22/2024 at 4:46 PM, the Administrator stated the hall nursing supervisors were responsible for completing the hospital transfer letters and mailing them to the resident's responsible party, then the supervisor provides the MDS Coordinator with a copy. The Administrator stated she was just made aware that the transfer letters do not include information about the State Agency, Ombudsman, or the resident's right to appeal and their transfer form did not have all of the correct information. At this time, the Administrator was made aware that the MDS Coordinator, nor the nursing staff, had been mailing the transfer letters.<br><br>2. A review of the transfer letters for Resident #90 included the resident's representative name, date, resident #90's name, the location, in which the resident was sent, the facility phone number, and Registered Nurse (RN) #7's name. No other information was listed on the document. A total of five letters were provided indicating the number of times the resident was sent to the hospital.<br><br>During an interview on 05/21/2024 at 11:16 PM, LPN #3 stated when a resident is sent to the hospital, she contacts the resident representative via phone and the facility was not required to send out a transfer letter.<br><br>During an interview on 05/22/2024 at 11:03 AM, LPN #9 stated when a resident is sent to the hospital, the facility calls the resident representative and does not send out a letter.<br><br>(continued on next page) |

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| F 0623<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During an interview on 05/22/204 at 12:03 PM, LPN #1 stated when a resident is sent to the hospital, the facility calls the resident representative and LPN #1 will fill out a letter and give it to upper management for them to mail out.<br><br>During an interview on 05/22/2024 at 1:07 PM, the MDS Coordinator stated when a resident is sent out to the hospital, she receives a copy of the transfer letter from the nursing staff but did not mail anything to the resident's responsible party.<br><br>During an interview on 05/22/2024 at 2:12 PM, the DON stated the hall nursing supervisors were responsible for completing the hospital transfer letters and mailing them to the resident's responsible party, then the supervisor provides the MDS Coordinator with a copy. The DON stated the only information provided on the transfer letter was the date the resident was sent out, where they were sent, and the reason for the transfer.<br><br>During an interview on 05/22/2024 at 4:46 PM, the Administrator stated the hall nursing supervisors were responsible for completing the hospital transfer letters and mailing them to the resident's responsible party, then the supervisor provides the MDS Coordinator with a copy. The Administrator stated she was just made aware that the transfer letters do not include information about the State Agency, Ombudsman, or the resident's right to appeal and their transfer form did not have all of the correct information. At this time, the Administrator was made aware that the MDS Coordinator, nor the nursing staff, had been mailing the transfer letters.<br><br>39839<br><br>3. On 05/22/2024 at 9:00 AM, Surveyor record review revealed Resident #31 was transferred to the hospital on 03/04/2024, 04/02/2024, 04/15/2024, and 05/16/2024. Further record review revealed the transfer notices sent with Resident #31 did not include the required contents such as a statement of the resident's appeal rights and the name, address, and telephone number of the Office of the State Long-Term Care Ombudsman.<br><br>On 05/22/2024 at 1:15PM, interview with the administrator confirmed that the facility's transfer notices did not include the required contents.<br><br>46004<br><br>4. Review of an Admission Record dated 05/22/2024 for Resident #26 reflected an [AGE] year-old female, admitted to the facility on [DATE] with diagnoses including essential hypertension, heart failure, unspecified dementia, dislocation of right hip, muscle weakness, cognitive communication deficit, and history of transient ischemic attack.<br><br>Review of an Un-Witnessed Fall Incident report dated 04/18/2024 at 19:40 (7:40 PM) for Resident #26 reflected the resident was 'assessed resident for injuries and pain .send to ED [emergency department] for eval [evaluation]' after a fall.<br><br>(continued on next page) |

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| F 0623<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Review of the written notification of transfer for the transfer to the hospital on 04/18/24 reflected, On 04/18/24, [Resident #26] was sent to [hospital name] in Batesville, Arkansas for a change of condition. If you have any questions or concerns, please call [telephone number]. The form did not include a notice to the Office of the State Long-Term Care Ombudsman, or the address/email/telephone number to the Office of the State Long-Term Care Ombudsman. |

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| F 0641<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure each resident receives an accurate assessment.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46004<br><br>Based on interview and record review, the facility failed to ensure the Minimum Data Set (MDS) assessment accurately reflected the resident's status for one (Resident #9) of four residents reviewed for assessment. Specifically, Resident #9's Quarterly MDS assessment indicated the resident had an ostomy. The resident did not have an ostomy.<br><br>Findings included:<br><br>Review of an Admission Record dated 05/22/2024 for Resident #9 reflected a [AGE] year-old female, admitted to the facility on [DATE] with diagnoses including dementia, constipation, and essential hypertension.<br><br>Review of an Annual MDS Assessment with an Assessment Reference Date (ARD) of 09/14/2023 for Resident #9, Section H indicated there was no ostomy.<br><br>Review of a Quarterly MDS Assessment with an ARD of 03/12/2024 for Resident #9, Section H indicated there was an ostomy. Section C indicated Resident #9 had a BIMS of 3, indicating impaired cognitive function.<br><br>Interview on 05/22/2024 at 8:10 AM with Licensed practical Nurse (LPN) #1, revealed Resident #9 did not have an ostomy.<br><br>Interview on 05/22/2024 at 12:31 PM with the Registered Nurse (RN) MDS Coordinator, revealed Resident #9 did not have an ostomy. She stated she would do a correction to the MDS assessment.<br><br>Review of a policy titled, MDS 3.0 Completion,' dated 02/2024, provided by the Administrator (ADM) as the current policy, reflected, .1. According to federal regulations, the facility conducts initially and periodically a comprehensive, accurate and standardized assessment of each resident's functional capacity . |

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| F 0656<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.<br><br>37526<br><br>Based on observations, interviews, record review, and the facility failed to develop, implement, and update a comprehensive person-centered care plan for 4 (Resident #85, Resident #90, Resident #31, and Resident #81) of 10 residents whose comprehensive care plans were reviewed. Specifically, the facility failed to ensure resident's falls were addressed appropriately in the care plan to prevent any further accidents and failed to follow the care plan related to falls.<br><br>Findings include:<br><br>A review of a facility policy titled, Comprehensive Care Plans, implemented on 04/2023, indicated, The comprehensive care plan will describe, at a minimum, the following: a. The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being . The comprehensive care plan will include measurable objectives and timeframes to meet the resident's needs as identified in the resident's comprehensive assessment. The objectives will be utilized to monitor the residents' progress. Alternative interventions will be documented, as needed . Qualified staff responsible for carrying out interventions specified in the care plan will be notified of their roles and responsibilities for carrying out the interventions, initially and when changes are made.<br><br>1. A review of the Admission Record, indicated the facility admitted Resident #85 with diagnoses that included Parkinson's disease, cognitive communication deficit, muscle weakness, difficulty walking, and cellulitis.<br><br>The Signification Change Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 02/27/2024, revealed Resident #85 had a Brief Interview for Mental Status (BIMS) score of 3 which indicated the resident had severe cognitive impairment. Further review of the MDS indicated the resident had two falls with no injury and one fall with major injury.<br><br>A review of Resident #85's Care Plan, initiated on 01/15/2024, revealed the resident was at risk for falls related to impaired balance and incontinence. Interventions included the following: padded floor mat to closed side of bed; document all behaviors which are not usual and report to nurse/doctor; keep call light, water, and frequently used items in reach; monitor for changes in condition that may warrant increased supervision/assistance and notify the doctor; review information on falls and attempt to determine cause of falls; staff to assist resident with performing activities of daily living (ADL) care as requested/needed; acute illness (with no context); medication review, obtain labs, staff education (with no context); pull tab alarm to wheelchair, Lap Buddy; family reports that resident gets out of bed and puts self on floor; attempt to take the resident out of the dining room after meals; behavior related (with no context); change cushion to wheelchair; numerous intervention successful (with no context); changed alarm clip (with no indication of which alarm); pressure pad alarm to bed; attempt nonskid shoes; changed wheelchair cushion, therapy; padded floor pad to open side of bed; attempt to adjust bed height to mark (with no context); and monitor sleep pattern.<br><br>(continued on next page) |

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| F 0656<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | A review of Resident #85's Incident and Accident (I&A) Reports since admission indicated the resident had a fall on 01/26/2024, 01/27/2024, two on 01/28/2024, two on 01/31/2024, 02/13/2024, 02/15/2024, two on 02/20/2024, two on 02/24/2024, 03/04/2024, 03/19/2024, 04/05/2024, 04/09/2024, 04/11/2024, 04/18/2024, 04/29/2024, 04/30/2024, two on 05/01/2024, 05/02/2024, 05/04/2024, 05/07/2024. The total number of incident reports indicated the resident had 25 falls since admission, one that resulted in a laceration above the resident's eyebrow and bruising to the face. These reports are not part of the resident's medical record.<br><br>A review of Family Care Plan Meeting Summary, dated 05/02/2024 indicated staff discussed the resident's two falls with the resident's spouse. There was nothing else documented about the falls. At the time of the meeting, the resident had 22 falls.<br><br>During an observation on 05/21/2024 at 9:23 AM, Resident #85 was sitting in their wheelchair near the nurse's desk with a cushion underneath the resident. The resident did not have a wheelchair alarm or a lap buddy present.<br><br>During an observation on 05/22/2024 at 7:21 AM, Resident #85 was sitting in their wheelchair in the dining room with a cushion underneath the resident. The resident did not have a wheelchair alarm or a lap buddy present and was wearing regular socks, not non-skid socks, and no shoes.<br><br>During an interview on 05/21/2024 at 6:05 PM, Resident #85's family member stated they were only aware of three to four falls that the resident had since admission. The family member stated she was only aware of fall interventions of a monitor to the resident's bed and chair.<br><br>During an interview on 05/21/2024 at 10:53 PM, Licensed Practical Nurse (LPN) #2 stated she was familiar with Resident #85 and that the resident thinks they can stand up and walk but could not. LPN #2 stated the resident's fall interventions included a mat on either side of the bed, a bed alarm but not a chair alarm, and to keep the resident close to the nurse's desk for observation. LPN #2 stated in order to know what interventions are in place, she would review the Incident and Accident (I&A) reports or call their supervisor and ask. LPN #2 stated the resident has a care plan, but the interventions are not listed there and are only located on the I&A. LPN #2 stated after a resident falls, they complete an I&A and the supervisor and/or Director of Nursing (DON) tells the staff what intervention needs to be put into place. LPN #2 stated they only document on the I&A for the fall and do not document anything in the resident's progress notes and that is how she was trained.<br><br>During an interview on 05/22/2024 at 7:25 AM, Certified Nursing Assistant (CNA) #4 stated she was familiar with Resident #90 and the resident had numeral falls that she was aware of. CNA #4 stated fall interventions for Resident #85 included a bed alarm and fall mats to both sides of the bed. CNA #4 stated the resident used to have a lap buddy and a chair alarm, but those were no longer in place. CNA #4 stated all fall interventions should be in the resident's care plan.<br><br>During an interview on 05/22/2024 at 7:28 AM, CNA #5 stated she was familiar with Resident #85 and the resident had fallen before because the resident will try to stand up and walk but the resident did not have any balance. CNA #5 stated the resident's fall interventions included an alarm on the resident's bed and chair and to just keep an eye on the resident. CNA #5 stated those interventions would be in the resident's care plan, but she had not reviewed Resident #85's care plan in a long time. When asked how she would know if fall interventions were changed, she stated the facility would place in-services at the nurse's station for updates.<br><br>(continued on next page) |

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| F 0656<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | During an interview on 05/22/2024 at 7:32 AM, LPN #6 stated she was familiar with Resident #85. LPN #6 stated fall interventions for Resident #85 included fall mats and a pressure pad to the resident's bed and that's all she was aware of. LPN #6 stated fall interventions should be included in the resident's care plan. LPN #6 stated when a resident falls, the nurse has to complete an I&A and the MDS Coordinator will place the interventions on the I&A and then update the resident's care plan. When asked if the interventions are listed on the I&A but not in the care plan, how staff would know what interventions were put into place and LPN #6 stated the nursing staff charts on the I&A for three days, in the note's sections, which is not part of the resident's medical record.<br><br>During an interview on 05/22/2024 at 8:12 AM, RN #7 stated she was familiar with Resident #85 and that the resident had numerous falls and for most of their falls, the resident would reach down like they were getting something off of the floor or the resident would throw their legs off the side of the bed and slide down and sit on the floor mat and that was how most of the falls happened. Registered Nurse (RN) #7 stated fall interventions for Resident #85 were a bed alarm and wedge cushion for the wheelchair. Previous interventions included therapy evaluation, a lap body, and another seat cushion. RN #7 stated those interventions were listed on the I&As, which are not part of the resident's medical record, but should also be included on the resident's care plan. RN #7 when completing an I&A for a fall, nursing staff have to document on the resident for three days in the notes section of the I&A and then the management team can discuss every fall and what intervention could be put into place. RN #7 stated nursing staff only document in the notes section within the I&A, which is not part of the resident's medical record and CNAs cannot access I&As. RN #7 stated the MDS Coordinator was responsible for updating the resident's care plan and she was made aware of the I&A during the daily morning meeting. RN #7 stated she reviewed care plans to ensure care plan interventions were transcribed appropriately based on the I&A. RN #7 stated CNAs are made aware of the interventions by having access to the resident's care plan, but most of the time, CNAs are made aware via in-services. At this time, RN #7 reviewed Resident #85's current care plan and stated based on the care plan, the resident should have a lap buddy and a wheelchair alarm. RN #7 stated an acute illness was not an appropriate intervention for a fall, nor was behavior. RN #7 stated that Staff educated was not enough information to indicate what staff were educated on related to falls. At this time, RN #7 stated she should not have said that she had reviewed the resident's care plan because it was not up to date.<br><br>(continued on next page) |

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| F 0656<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | During an interview on 05/22/2024 at 9:06 AM, LPN #8 stated she was familiar with Resident #85 and that the resident had some falls and that the resident liked to kneel in the floor in the resident's room. LPN #8 stated she would have to look up fall interventions for the resident and could not recall any off the top of her head, but the facility had tried a pressure pad alarm and fall mats and current interventions should be on the resident's care plan. Per LPN #8, the MDS Coordinator was responsible for updating the resident's care plan and was not aware of anyone else that had access to editing the resident's care plan. LPN #8 stated after a resident falls, the nursing staff completes an I&A and the resident's fall intervention for that fall is placed on the I&A. LPN #8 stated the MDS Coordinator is either emailed or the I&A is discussed during the morning meeting and that is how she is made aware of what intervention needs to be added to the resident's care plan. LPN #8 stated they only document on the resident's fall within the I&A, which is not part of the resident's medical record. LPN #8 stated she frequently checked the resident's care plan for accuracy and discussed interventions during the morning meeting. At this time, LPN #8 also reviewed the resident's current care plan and stated the resident had a current intervention of a lap buddy, but it thought it had been revised to a different intervention and it should not be on the resident's care plan. LPN #8 stated that acute illness was not an intervention and that staff education listed as an intervention did not provide was education was provided. When asked if intervention successful with no context was an appropriate intervention, she stated she would have to look at the IA& to see what the intervention was because it was not listed on the care plan. LPN #8 stated that per the resident's care plan, an alarm should be on the resident's wheelchair but was unaware if one was in place.<br><br>During an interview on 05/22/2024 at 11:03 AM, LPN #9 stated she was familiar with Resident #85 has had many falls and one of the resident's falls resulted in a bruised face, was sent to the hospital, and had to have a laceration to their face glued. LPN #9 stated the resident had previous fall interventions that included a lap buddy, alarms, and a wedge cushion for the resident's wheelchair. LPN #9 stated that fall interventions would be included on the resident's care plan and that she did not complete any I&As because she only dealt with wounds.<br><br>During an interview on 05/22/2024 at 1:07 PM, the MDS Coordinator reviewed Resident #85's I&As and stated the resident had 24 falls since admission. At this time, the MDS Coordinator reviewed the resident's care plan and stated that she had discontinued the intervention of the lap buddy and the wheelchair alarm for resident #85 because she was instructed to do so by RN #7 that morning. The MDS Coordinator stated that based on the care plan, the resident should have had a lap buddy and a wheelchair alarm. The MDS Coordinator stated that acute illness that was listed as an intervention should not be considered an intervention, as well as staff education. The MDS Coordinator stated, behavior related and interventions successful listed as an intervention was not appropriate because it did not provide any details. The MDS Coordinator stated she only put the interventions on the resident's care plan based on the interdisciplinary team's decision during the morning meetings and that she does not review the actual I&A and is only verbally told about the resident's fall. The MDS Coordinator stated the resident's care plan did not clearly define interventions listed for the nursing staff to follow and the DON was responsible for oversight of the care plan process.<br><br>(continued on next page) |

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| | 045317 | A. Building<br>B. Wing | 05/22/2024 |

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| Wood-Lawn Heights | 2800 Neeley Street<br>Batesville, AR 72501 |

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| F 0656<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | During an interview on 05/22/2024 at 2:12 PM, the DON stated she was only aware of fall interventions of floor mats and non-skid socks and would have to review the I&As for other interventions for Resident #85. The DON stated fall interventions should be in the resident's care plan and LPNs could review the I&A report. The DON stated that when a resident falls, nursing staff are to document everything related to the fall within the I&A report, which is not part of the medical record. The DON stated that nursing staff, not including CNAs, have access to the I&A reports. The DON stated the MDS Coordinator was responsible for updating the resident's care plan, that she was on the Interdisciplinary Team (IDT), and was verbally told how to update the resident's care plan and was not provided with the actual I&A report to review. The DON stated she reviewed the resident's care plan weekly to ensure interventions were transcribed accurately and there was no auditing process for accuracy of the care plan, and she was responsible for oversight of the accuracy of the care plans. The DON stated that CNAs were made aware of fall interventions by reviewing the resident's care plan. The DON stated the intervention of the lap buddy should have been removed from the resident's care plan on 04/16/2024 but was not due to an oversight. The DON also stated that she had just completed training and was made aware that acute illness could not be used as an intervention and the facility had stopped using that intervention, however, the facility did not go back and correct current care plans to discontinue acute illness as an intervention. The DON stated that behavior should not have been listed as an intervention because it was the cause of the fall and not an intervention. The DON stated staff educated was an appropriate intervention, however the care plan did not indicate what education was provided. The DON also verified that the resident did not have a wheelchair alarm and it should have been discontinued from the resident's care plan. The DON stated staff should update the resident's care plan when an intervention needs to be discontinued.<br><br>During an interview on 05/22/2024 at 4:46 PM, the Administrator stated she was aware that falls were an issue within the facility, and she expected her staff to update the resident's care plan timely and accurately and interventions should be removed from the care plan if they were no longer effective.<br><br>2. A review of the Admission Record, indicated the facility admitted Resident #90 with diagnoses that included age related cognitive decline, muscle weakness, cognitive communication deficit, difficulty walking, dementia, and vertigo.<br><br>The Signification Change MDS, with an ARD of 04/17/2024, revealed Resident #90 had a BIMS score of 5 which indicated the resident had severe cognitive impairment. Further review of the MDS indicated the resident had two falls with no injury and one fall with major injury.<br><br>A review of Resident #90's Care Plan, initiated on 11/07/2023, revealed the resident was at risk for falls related to impaired balance, incontinence, and poor awareness of safety needs. Interventions included4 acute illness (with no context); family education (with no context); padded floor pad to open side of bed; grip around bathroom bar; staff education (with no context); staff changed intervention after requesting I&As (with no context); attempt grip socks at bedtime; anti-rollbacks to wheelchair, document all behaviors which are not usual for the resident and report to nurse/doctor; keep call light, water, and frequently used items in reach; monitor for changes in condition that may warrant increased supervision/assistance and notify the doctor; review information on falls and attempt to determine cause of falls; and staff to assist with performing ADL care as requested/needed.<br><br>(continued on next page) |

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| F 0656<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | A review of Resident #90's Incident and Accident reports since admission indicated the resident had a fall on 11/26/2024 (outside of the facility), 12/07/2024, 01/28/2024, 03/04/2024, 03/07/2024, 04/11/2024, 04/19/2024, and 04/24/2024. The total number of incident reports indicated the resident had eight falls since admission, one that resulted in a fractured back, and one resulted in a hematoma to the left side of their forehead.<br><br>A review of Fall Risk Evaluation indicated Resident #90 was evaluated for falls nine times since the resident was admitted . Seven of the evaluations indicated the type as Post Fall and all nine evaluations indicated the resident was At Risk for falls. Each Fall Risk Evaluation included level of consciousness, history of falls, ambulation status, vision status, balance, blood pressure, medication, change in mental status, and predisposing disease. The evaluations did not include any other information, such as interventions.<br><br>During an interview on 05/21/2024 at 11:16 PM, the LPN #3 stated she was familiar with Resident #90 and was aware the resident had a fall that resulted in a fractured back. LPN #13 stated the resident had fall interventions that included non-skid strips in the resident's bathroom and then stated she needed to look at the resident's I&As to see what other fall interventions the resident had. LPN #13 stated she was trained to put the fall interventions in the I&A and that was the only place she knew to look for fall interventions. LPN #13 stated that CNAs do not have access to view the I&A and only nurses do. When asked how CNAs are made aware of the interventions, since they do not have access to the I&As, she stated the nurses verbally tell the CNAs in report and sometimes there are in-services completed. When asked if the interventions should also be in the resident's care plan, LPN #3 stated they should, but nurses do not do anything with the care plan and just review the I&As. LPN #3 verified that the MDS Coordinator updates the resident's care plan. LPN #3 stated when completing an I&A, the DON would typically tell the nurse what intervention to include, but if the previous intervention was successful, the nurse would just document interventions successful.<br><br>During an interview on 05/22/2024 at 11:19 AM, LPN #15 stated she was familiar with Resident #90, that the resident had numerous falls in which one fall resulted in the resident fracturing their back and another resulted in bruising to the resident's face because the resident was unsteady on their feet. LPN #15 stated the resident had fall interventions of fall mats to the side of the resident's bed, non-skid socks, and shoes, and had been placed in a wheelchair after the fall resulting in the fractured back. LPN #15 stated the interventions should be in the resident's care plan. LPN #15 stated after a resident falls, the nurse completes an I&A, and the DON assists the nurse with putting a fall intervention on the I&A. LPN #15 stated the MDS Coordinator was responsible for updating the resident's care plan and LPN #15 did not review the care plan for accuracy. At this time, LPN #15 reviewed Resident #90's care plan and stated the interventions of family and staff education should include what the family and staff were educated on. LPN #15 stated the care plan did not identify all interventions clearly in order for a certified nursing assistant (CNA) to understand.<br><br>During an interview on 05/22/2024 at 11:50 AM, CNA #10 stated she was familiar with Resident #90 and was aware the resident had a fall that resulted in a fractured back and one that resulted in a bruise to the resident's forehead. CNA #10 stated fall interventions included the resident was now in a wheelchair, making sure the resident had shoes on, and redirecting the resident. CNA #10 stated she would have to ask what other interventions the resident had. CNA #10 stated acute illness and family education listed as an intervention on the resident's care plan was not enough information for her to know what the actual intervention was.<br><br>(continued on next page) |

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| F 0656<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | During an interview on 05/22/204 at 12:03 PM, LPN #1 stated she was familiar with Resident #90 and the resident was always looking for something to do, such as folding clothes. LPN #1 stated she was aware of the fall interventions of floor mats but could not recall any other interventions and she would have to look at the resident's care plan. At this time, LPN #1 reviewed the resident's care plan and stated the care plan did not identify the interventions clearly, however, the older CNAs would know but the newer CNAs might not know what the interventions were. When asked how acute illness was an intervention, LPN #1 stated the DON would have to answer that question. LPN #1 stated the intervention regarding family education did not state what the actual intervention was and should include what the family was educated on. LPN #1 stated staff should know what those interventions mean and when the LPN was asked how, LPN #1 stated, I don't know. LPN #1 stated the MDS Coordinator was responsible for updating the resident's care plan and the DON or Assistant Director of Nursing (ADON) should monitor the care plan for accuracy.<br><br>During an interview on 05/22/2024 at 12:51 PM, the MDS Coordinator reviewed Resident #90's I&As and stated the resident had 8 falls since admission with some resulting in injury. At this time, the MDS Coordinator reviewed the resident's care plan and stated she updated the intervention of staff education yesterday as instructed to do so by the DON. The MDS Coordinator stated every morning during the morning meeting, the IDT verbally tells her what interventions to put in the resident's care plan and was told to include acute illness as an intervention. The MDS Coordinator stated the intervention of family education did not provide enough detail. The MDS Coordinator stated either a nurse or the IDT team notifies her if an intervention should be discontinued. The MDS Coordinator stated she was part of the IDT team and when she was asked about completing a root cause analysis, the MDS Coordinator stated the team reviews the previous fall interventions but was not sure if this meeting was documented anywhere.<br><br>During an interview on 05/22/2024 at 2:12 PM, the DON stated fall interventions should be in the resident's care plan and LPNs could review the I&A report. The DON stated that when a resident falls, nursing staff are to document everything related to the fall within the I&A report, which is not part of the medical record, and nothing related to the fall should be within the medical record. The DON stated that nursing staff, not including CNAs, have access to the I&A reports. The DON stated the MDS Coordinator was responsible for updating the resident's care plan, that she was on the IDT team, and was verbally told how to update the resident's care plan and was not provided with the actual I&A report to review. The DON stated she reviewed the resident's care plan weekly to ensure interventions were transcribed accurately and there was no auditing process for accuracy of the care plan, and she was responsible for oversight of the accuracy of the care plans. The DON stated that CNAs were made aware of fall interventions by reviewing the resident's care plan. The DON also stated that she had just completed training and was made aware that acute illness could not be used as an intervention and the facility had stopped using that intervention, however, the facility did not go back and correct current care plans to discontinue acute illness as an intervention. The DON stated that behavior should not have been listed as an intervention because it was the cause of the fall and not an intervention. The DON stated staff educated was an appropriate intervention, however the care plan did not indicate what education was provided. The DON stated all falls are documented within Risk Management, which was not part of the resident's medical record and staff were instructed to put all notes related to the fall within the I&A in Risk Management. The DON stated staff should update the resident's care plan when an intervention needs to be discontinued.<br><br>37878<br><br>(continued on next page) |

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| F 0656<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | 3. A review of the Admission Record, indicated Resident #81 with diagnoses of Alzheimer's disease, Parkinsonism, dementia with behavioral disturbance, repeated falls, anemia, and type 2 diabetes mellitus.<br><br>The Signification Change MDS, with an ARD of 04/02/2024, revealed Resident #81 had a BIMS score of 6 which indicated the resident had severe cognitive impairment.<br><br>A review of Resident #81's Comprehensive Care Plan revealed the resident was at risk for bleeding date initiated 10/24/2024, interventions included to administer antiplatelet medication as ordered; at risk for easily bruising or skin tears. Nurse to notify doctor of any new skin issues. The care plan did not include any intervention to protect skin.<br><br>During an observation on 05/22/2024 at 8:36 AM, Resident #81 was sitting in a common area in a wheelchair, wearing a short sleeve shirt. Multiple reddened to purple discolorations to both forearms and tops of hands were observed.<br><br>During a concurrent observation and interview on 05/22/2024 at 8:40 AM, CNA #16 confirmed Resident #81 had discolorations to both arms and tops of hands and had no interventions in place to protect the skin.<br><br>During a concurrent observation and interview on 05/22/2024 at 8:52 AM, LPN #17 confirmed Resident #81 had discolorations to both arms and tops of hands and had no interventions in place to protect the skin.<br><br>During a concurrent observation and interview on 05/22/2024 at 12:34 PM, LPN #9, Treatment Nurse, confirmed Resident #81 had discolorations to both arms and tops of hands and had no interventions in place to protect the skin.<br><br>During a concurrent observation and interview on 05/22/2024 at 12:52 PM, LPN Supervisor #8 confirmed Resident #81 had discolorations to both arms and tops of hands and had no interventions in place to protect the skin.<br><br>On 05/22/24 at 3:50 PM LPN, Hall Supervisor #8 provided a policy titled, 'Skin Audits by Nursing Assistants' date implemented 3/13/23, date reviewed/revised 01/03/2024. Nursing assistants shall inspect all skin surfaces during bath/shower and report any concerns to the resident's nurse immediately after the task. Nursing assistants shall report changes in skin condition that are noted during any care procedure. Skin conditions that shall be reported include but are not limited to: redness bruising swelling rashes, hives, blisters, skin tears, open areas, ulcers, lesions.'<br><br>39839<br><br>(continued on next page) |

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| F 0656<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | 4. A record review revealed Resident #31 had a fall on 03/31/2024, with no injuries noted. Resident #31's Care Plan titled, I am at risk for falls related to history of falls, impaired balance, and incontinence listed a new intervention for padded floor pads to the open and closed side of bed that was initiated on 04/01/2024. Further record review revealed Resident #31 had another fall on 04/02/2024 and was transferred to the acute hospital for evaluation. Review of Resident #31's care plan for risk for falls listed acute illness as a new intervention that was initiated on 04/03/2024. Additional record review revealed Resident #31 had another fall on 04/27/2024 with no injuries noted. Review of Resident #31's fall risk care plan revealed a new intervention to place a grip around the toilet handrail that was initiated on 04/29/2024.<br><br>On 05/21/2024 at 1:45PM, Surveyor observation revealed that Resident #31's bed was in the low position and included fall mats to both sides of the bed.<br><br>On 5/22/24 at 2:15PM, an interview with the DON revealed acute illness was listed as an intervention because if you treat the illness, the main cause of the fall would be taken care of. However, the DON further stated that she was recently educated at a nursing conference not to use acute illness as an intervention and the facility stopped this practice. The DON confirmed that acute illness is not really a fall prevention intervention, and the facility has not discontinued the intervention from Resident #31's care plan.<br><br>46004 |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate treatment and care according to orders, resident's preferences and goals.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46004<br><br>Based on observation, interview, and record review, it was determined the facility failed to ensure each resident received treatment and care in accordance with the comprehensive person-centered care plan for one (Resident #6) of three residents reviewed. Specifically, the facility did not document blood pressures before administration of a blood pressure lowering medication with hold parameters. These failures had the potential to cause residents to experience unwanted side effects of medications such as lightheadedness, dizziness, and falls causing major injuries.<br><br>Findings included:<br><br>Review of Resident #6's Admission Record dated 05/22/2024 reflected an admitted [DATE] with diagnoses including essential hypertension, history of transient ischemic attack (mini-stroke), muscle weakness and unsteadiness on feet.<br><br>Observation on 05/21/2024 at 1:00 PM revealed Resident #6 was in bed, sleeping. Resident #6 did not speak to the Surveyor.<br><br>Review of Resident #6's Significant Change Minimum Data Set (MDS) assessment dated [DATE] reflected an active diagnosis of hypertension.<br><br>Review of Resident #6's Quarterly MDS assessment dated [DATE] reflected a Brief Interview for Mental Status (BIMS) score of 5, suggesting a severe cognitive impairment (lots of difficulty in making daily decisions about care). In addition, there was an active diagnosis of hypertension.<br><br>Review of Resident #6's Care Plan initiated on 05/10/2023 and last revised on 10/20/2023 reflected a focus area of being at risk for complications r/t (related to) hypertension. Interventions included, .Obtain blood pressure readings as ordered (at least weekly) notify MD [Medical Doctor] of significant readings .<br><br>Review of Resident #6's May 2024 Order Summary Report reflected an order dated 05/10/2023 for, Losartan Potassium oral tablet 25 mg [milligrams] .give 1 tablet by mouth one time a day related to Essential (primary) hypertension .Hold if SBP <110 [systolic blood pressure less than 110], and/or DBP <50 [diastolic less than 50] .<br><br>Review of Resident #6's May 2024 Medication Administration Record (MAR) reflected Losartan Potassium 25 mg give one tablet by mouth one time a day, ordered on 05/11/2023, with instructions to, Hold if SBP <110, and/or DBP <50. Further review reflected the medication was administered 05/01/2024 through 05/15/2024, and 05/18/2024 through 05/21/2024, and no documented blood pressures with the administration of the blood pressure lowering medications.<br><br>Interview on 05/22/2024 at 1:07 PM with Licensed Practical Nurse (LPN) A revealed the blood pressures for the administration of Resident #6's Losartan were not documented in the EMR (electronic medical record).<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Interview on 05/22/2024 at 2:12 PM with the Director of Nursing (DON) revealed the expectation was staff followed physician's orders, if blood pressure parameters were ordered then the residents' blood pressure should be assessed.<br><br>Review of the facility's policy titled, Medication Administration dated April 2024, provided by the Administrator (ADM) as the current policy, reflected, .4. Obtain and record vital signs, when applicable or per physician orders. When applicable, hold medication for those vital signs outside the physician's prescribed parameters . 15. Sign MAR after administered. For those medications requiring vital signs, record the vital signs onto the MAR .<br><br>Review of the facility's policy titled, Pharmacy Services,' dated 02/2024 provided by the ADM as the current policy, reflected, .7. The pharmacist is responsible for helping the facility obtain and maintain timely and appropriate pharmaceutical services that support residents' healthcare needs, goals and quality of life that are consistent with current standards of practice and meet state and federal requirements . |

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| F 0689<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>37526<br><br>Based on observations, record review, interviews, and facility policy review, the facility failed to investigate to determine the causative factors of falls to facilitate development of effective interventions to prevent further falls and minimize the risk of fall-related injuries and failed to ensure current fall documentation and interventions were accessible to all direct care staff for 2 (Resident #85 and Resident #90) of 3 residents reviewed for falls. These failures led to falls resulting in a laceration to the head and bruising to the eyes for Resident #85 and a fractured back and a hematoma to the forehead for Resident #90. The facility also failed to ensure interventions were developed and implemented to decrease the risk of skin tears and/or skin discolorations for 1 (Resident #81) of 3 residents reviewed for falls.<br><br>Findings include:<br><br>A review of a facility policy titled, Fall Procedure, with an effective date of 03/08/2022, indicated, Purpose: 1. To assess residents at risk for falls. 2. To follow up and evaluate all falls. 3. To identify the reason for the fall. 4. To prepare a plan of care to reduce the potential for injury related to falls.<br><br>A review of a facility policy titled, Accidents and Supervision, with a reviewed date of 02/02/2024, indicated, Each resident will receive adequate supervision and assistive devices to prevent accidents. This includes: 1. Identifying hazard(s) and risk(s). 2. Evaluating and analyzing hazard(s) and risk(s). 3. Implementing interventions to reduce hazard(s) and risk(s). 4. Monitoring for effectiveness and modifying interventions when necessary . Monitoring and modification processes include: a. Ensuring that interventions are implemented correctly and consistently b. Evaluating the effectiveness of interventions c. Modifying or replacing interventions as needed d. Evaluating the effectiveness of new interventions.<br><br>1. A review of the Admission Record, indicated the facility admitted Resident #85 with diagnoses that included Parkinson's disease, cognitive communication deficit, muscle weakness, difficulty walking, and cellulitis.<br><br>The Signification Change Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 02/27/2024, revealed Resident #85 had a Brief Interview for Mental Status (BIMS) score of 3 which indicated the resident had severe cognitive impairment. Further review of the MDS indicated the resident had two falls with no injury and one fall with major injury.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | A review of Resident #85's Care Plan, initiated on 01/15/2024, revealed the resident was at risk for falls related to impaired balance and incontinence. Interventions included the following: padded floor mat to closed side of bed; document all behaviors which are not usual and report to nurse/doctor; keep call light, water, and frequently used items in reach; monitor for changes in condition that may warrant increased supervision/assistance and notify the doctor; review information on falls and attempt to determine cause of falls; staff to assist resident with performing activities of daily living (ADL) care as requested/needed; acute illness (with no context); medication review, obtain labs, staff education (with no context); pull tab alarm to wheelchair, Lap Buddy; family reports that resident gets out of bed and puts self on floor; attempt to take the resident out of the dining room after meals; behavior related (with no context); change cushion to wheelchair; numerous intervention successful (with no context); changed alarm clip (with no indication of which alarm); pressure pad alarm to bed; attempt nonskid shoes; changed wheelchair cushion, therapy; padded floor pad to open side of bed; attempt to adjust bed height to mark (with no context); and monitor sleep pattern.<br><br>A review of Resident #85's Progress Notes from 01/10/2024 through 05/21/2024 did not include any notes directly related to any falls. On 01/16/2024 at 1:54 PM, Registered Nurse (RN) #7 indicated the resident had a self-reported fall on 01/14/2024. There were no additional notes related to the fall. On 02/01/2024 at 3:00 P. M., the Director of Nursing (DON) indicated on a Skin only note that the resident did not have an injury from a fall. There were no additional notes related to the fall. On 02/15/2024 at 10:19 PM, Licensed Practical Nurse (LPN) #6 indicated there was no acute fracture on an x-ray that was complete. On 02/16/2024 at 9:38 AM, LPN #8 indicated the x-ray was ordered for the resident's left shoulder related to pain from a fall. At 10:29 AM, RN #11 indicated on a Long Term Care Evaluation the resident had an unwitnessed fall on 02/13/2024 in the resident's room. On 02/20/2024 at 2:42 P.M., LPN #8 indicated the resident lowered themselves to the floor from their wheelchair and was assisted back into their wheelchair. On 02/27/2024 at 9:22 A.M., the MDS Coordinator indicated the resident was reviewed for the upcoming interdisciplinary meeting, but no other information was provided. On 04/15/2024 at 12:57 AM, RN #7 indicated in a Long Term Care Evaluation that on 04/11/2024, the resident had a witnessed fall with no injury. There were no additional notes related to the fall. On 04/18/2024 at 6:07 PM, LPN #12 indicated the resident was sent to the hospital to be evaluated. At 10:51 PM, the resident returned to the facility with a glued laceration with no indication of where the laceration was. Based on the review of the progress notes, the resident had four falls.<br><br>A review of Resident #85's Incident and Accident Reports since admission indicated the resident had a fall on 01/26/2024, 01/27/2024, two on 01/28/2024, two on 01/31/2024, 02/13/2024, 02/15/2024, two on 02/20/2024, two on 02/24/2024, 03/04/2024, 03/19/2024, 04/05/2024, 04/09/2024, 04/11/2024, 04/18/2024, 04/29/2024, 04/30/2024, two on 05/01/2024, 05/02/2024, 05/04/2024, 05/07/2024. The total number of incident reports indicated the resident had 25 falls since admission, one that resulted in a laceration above the resident's eyebrow and bruising to the face. These reports are not part of the resident's medical record.<br><br>A review of Fall Risk Evaluation indicated Resident #85 was evaluated for falls 22 times since the resident was admitted . Thirteen of the evaluations indicated the type as Post Fall and all 22 evaluations indicated the resident was At Risk for falls. Each Fall Risk Evaluation included level of consciousness, history of falls, ambulation status, vision status, balance, blood pressure, medication, change in mental status, and predisposing disease.<br><br>(continued on next page) |

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| | 045317 | A. Building<br>B. Wing | 05/22/2024 |

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| Wood-Lawn Heights | 2800 Neeley Street<br>Batesville, AR 72501 |

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| F 0689<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | A review of Family Care Plan Meeting Summary, dated 05/02/2024 indicated staff discussed the resident's two falls with the resident's spouse. There was nothing else documented about the falls. At the time of the meeting, the resident had 22 falls.<br><br>During an observation on 05/21/2024 at 9:23 AM, Resident #85 was sitting in their wheelchair near the nurse's desk with a cushion underneath the resident. The resident did not have a wheelchair alarm or a lap buddy present.<br><br>During an observation on 05/22/2024 at 7:21 AM, Resident #85 was sitting in their wheelchair in the dining room with a cushion underneath the resident. The resident did not have a wheelchair alarm or a lap buddy present and was wearing regular socks, not non-skid socks, and no shoes.<br><br>During an interview on 05/21/2024 at 6:05 PM, Resident #85's family member stated, they were only aware of three to four falls that the resident had since admission. The family member stated she was only aware of fall interventions of a monitor to the resident's bed and chair.<br><br>During an interview on 05/21/2024 at 10:53 PM, LPN #2 stated she was familiar with Resident #85 and that the resident thinks they can stand up and walk but could not. She stated she was unaware of how many falls the resident had but has fallen quite a bit at night though. LPN #2 stated the resident would roll out of bed and onto the fall mat and one of the falls resulted in a gash above the resident's eyebrow and was sent to the hospital. LPN #2 stated the resident had another fall in which the resident hit their head and was sent to the hospital for that fall. LPN #2 stated the resident's fall interventions included a mat on either side of the bed, a bed alarm but not a chair alarm, and to keep the resident close to the nurse's desk for observation. LPN #2 stated in order to know what interventions are in place, she would review the Incident and Accident (I&A) reports or call their supervisor and ask. LPN #2 stated the resident has a care plan, but the interventions are not listed there and are only located on the I&A. LPN #2 stated the interventions are in the LPN Guideline book, located at the nurse's desk. LPN #2 stated after a resident falls, they complete an I&A and the supervisor and/or DON tells the staff what intervention needs to be put into place. LPN #2 stated they only document on the I&A for the fall and do not document anything in the resident's progress notes and that is how she was trained.<br><br>During an interview on 05/22/2024 at 7:25 AM, Certified Nursing Assistant (CNA) #4 stated she was familiar with Resident #90 and the resident had numeral falls that she was aware of. CNA #4 stated the last couple of falls have occurred during the night and one fall resulted in the resident hitting their head. CNA #4 stated fall interventions for Resident #85 included a bed alarm and fall mats to both sides of the bed. CNA #4 stated the resident used to have a lap buddy and a chair alarm, but those were no longer in place. CNA #4 stated all fall interventions should be in the resident's care plan.<br><br>During an interview on 05/22/2024 at 7:28 AM, CNA #5 stated she was familiar with Resident #85 and the resident had fallen before because the resident will try to stand up and walk but the resident did not have any balance. CNA #5 stated she thought the resident may have had an injury from a fall, but it was a while ago. CNA #5 stated the resident's fall interventions included an alarm on the resident's bed and chair and to just keep an eye on the resident. CNA #5 stated those interventions would be in the resident's care plan, but she had not reviewed Resident #85's care plan in a long time. When asked how she would know if fall interventions were changed, she stated the facility would place in-services at the nurse's station for updates.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | During an interview on 05/22/2024 at 7:32 AM, LPN #6 stated she was familiar with Resident #85 and that the resident had numerous falls, one including where the resident hit their head and one that resulted in the resident receiving a laceration above the resident's eyebrow. LPN #6 stated she had walked in on the resident on their knees on the fall mat. LPN #6 stated fall interventions for Resident #85 included fall mats and a pressure pad to the resident's bed and that's all she was aware of. LPN #6 stated fall interventions should be included in the resident's care plan. LPN #6 stated when a resident falls, the nurse has to complete an I&A and the MDS Coordinator will place the interventions on the I&A and then update the resident's care plan. LPN #6 stated that all information related to the fall goes on the I&A form and not in the resident's progress notes. When asked if the interventions are listed on the I&A but not in the care plan, how staff would know what interventions were put into place and LPN #6 stated the nursing staff charts on the I&A for three days, in the note's sections, which is not part of the resident's medical record. LPN #6 stated there was an LPN Guideline book, as referenced by LPN #2, and at this time, she reviewed the Guideline book three times with the Surveyor present and was unable to locate current information related to falls. The documentation within the binder was how to complete a fall investigation based on the previous electronic health record system. When asked how she was aware of the process related to falls if the LPN Guideline book was not up to date, she stated she was trained on how to complete an I&A by another staff member.<br><br>During an interview on 05/22/2024 at 8:12 AM, Registered Nurse (RN) #7 stated she was familiar with Resident #85 and that the resident had numerous falls and for most of their falls, the resident would reach down like they were getting something off of the floor or the resident would throw their legs off the side of the bed and slide down and sit on the floor mat and that was how most of the falls happened. RN #7 was not aware of any injuries related to falls for Resident #85. RN #7 stated fall interventions for Resident #85 was a bed alarm and wedge cushion for the wheelchair. Previous interventions included therapy evaluation, a lap body, and another seat cushion. RN #7 stated those interventions were listed on the I&As, which are not part of the resident's medical record, but should also be included on the resident's care plan. RN #7 when completing an I&A for a fall, nursing staff have to document on the resident for three days in the notes section of the I&A and then the management team can discuss every fall and what intervention could be put into place. RN #7 stated nursing staff only document in the notes section within the I&A, which is not part of the resident's medical record and CNAs cannot access I&As. RN #7 stated the MDS Coordinator was responsible for updating the resident's care plan and she was made aware of the I&A during the daily morning meeting. RN #7 stated she reviewed care plans to ensure care plan interventions were transcribed appropriately based on the I&A. RN #7 stated CNAs are made aware of the interventions by having access to the resident's care plan, but most of the time, CNAs are made aware via in-services. When asked about if the facility has completed a root cause analysis of Resident #85, RN #7 stated the facility looks at each fall and comes up with interventions, however, she is not aware of the facility completing a root cause analysis because the facility just looks at each individual fall and not falls as a whole. RN #7 stated the DON was responsible for keeping the LPN Guideline book up to date. When providing the guidelines for falls that were pulled from the guideline book, RN #7 verified the binder was not accurate and the documentation was based on the facilities previous electronic health record system. At this time, RN #7 reviewed Resident #85's current care plan and stated based on the care plan, the resident should have a lap buddy and a wheelchair alarm. RN #7 stated an acute illness was not an appropriate intervention for a fall, nor was behavior. RN #7 stated that Staff educated was not enough information to indicate what staff were educated on related to falls. At this time, RN #7 stated she should not have said that she had reviewed the resident's care plan because it was not up to date.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | During an interview on 05/22/2024 at 9:06 AM, LPN #8 stated she was familiar with Resident #85 and that the resident had some falls and that the resident liked to kneel in the floor in the resident's room. LPN #8 stated she would have to look up fall interventions for the resident and could not recall any off the top of her head, but the facility had tried a pressure pad alarm and fall mats and current interventions should be on the resident's care plan. Per LPN #8, the MDS Coordinator was responsible for updating the resident's care plan and was not aware of anyone else that had access to editing the resident's care plan. LPN #8 stated after a resident falls, the nursing staff completes an I&A and the resident's fall intervention for that fall is placed on the I&A. LPN #8 stated the MDS Coordinator is either emailed or the I&A is discussed during the morning meeting and that is how she is made aware of what intervention needs to be added to the resident's care plan. LPN #8 stated they only document on the resident's fall within the I&A, which is not part of the resident's medical record and the only time the staff chart in the resident's medical record would be an instance if the resident's family member refused to send the resident to the hospital related to the fall. LPN #8 stated she frequently checked the resident's care plan for accuracy and discussed interventions during the morning meeting. LPN #8 was not aware of what a root cause analysis for falls was and had not been part of a root cause analysis. LPN #8 stated that the RN Supervisor was responsible for going through the LPN Guideline book to ensure everything was up to date. At this time, LPN #8 was shown the guidance for incidents and stated it was the facility's previous electronic health record system guidance. At this time, LPN #8 also reviewed the resident's current care plan and stated the resident has a current intervention of a lap buddy, but it thought it had been revised to a different intervention and it should not be on the resident's care plan. LPN #8 stated that acute illness was not an intervention and that staff education listed as an intervention did not provide was education was provided. When asked if intervention successful with no context was an appropriate intervention, she stated she would have to look at the IA& to see what the intervention was because it was not listed on the care plan. LPN #8 stated that per the resident's care plan, an alarm should be on the resident's wheelchair but was unaware if one was in place.<br><br>During an interview on 05/22/2024 at 11:03 AM, LPN #9 stated she was familiar with Resident #85 has had many falls and one of the resident's falls resulted in a bruised face, was sent to the hospital, and had to have a laceration to their face glued. LPN #9 stated the resident had previous fall interventions that included a lap buddy, alarms, and a wedge cushion for the resident's wheelchair. LPN #9 stated that the resident would repeatedly get down on the floor to fix their airplane. LPN #9 stated the resident's falls resulted in numerous skin tears and though the resident may have had a fracture but could not remember when. LPN #9 stated that fall interventions would be included on the resident's care plan and that she did not complete any I&As because she only dealt with wounds.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | During an interview on 05/22/2024 at 1:07 PM, the MDS Coordinator reviewed Resident #85's I&As and stated the resident had 24 falls since admission. At this time, the MDS Coordinator reviewed the resident's care plan and stated that she had discontinued the intervention of the lap buddy and the wheelchair alarm for resident #85 because she was instructed to do so by RN #7 that morning. The MDS Coordinator stated that based on the care plan, the resident should have had the lap buddy and the wheelchair alarm. The MDS Coordinator stated that acute illness that was listed as an intervention should not be considered an intervention, as well as staff education. The MDS Coordinator stated, behavior related and interventions successful listed as an intervention was not appropriate because it did not provide any details. The MDS Coordinator stated she only put the interventions on the resident's care plan based on the interdisciplinary team's decision during the morning meetings and that she does not review the actual I&A and is only verbally told about the resident's fall. The MDS Coordinator stated the resident's care plan did not clearly define interventions listed for the nursing staff to follow and the DON was responsible for oversight of the care plan process.<br><br>During an interview on 05/22/2024 at 2:12 PM, the DON stated that the facility had determined Resident #85, per the resident's family, would place themselves on the floor. The DON stated she was not aware of how many falls the resident had since they had been admitted to the facility. The DON stated she had printed off the I&As for the survey team and at this time, she was provided with the I&As and stated the resident had 24 falls since admission. The DON stated Resident #85 had an injury that included a laceration to their eyebrow but was not sure if the resident had a major injury. The DON stated she was only aware of fall interventions of floor mats and non-skid socks and would have to review the I&As for other interventions. The DON stated fall interventions should be in the resident's care plan and LPNs could review the I&A report. The DON stated that when a resident falls, nursing staff are to document everything related to the fall within the IA& report, which is not part of the medical record, and nothing related to the fall should be within the medical record. The DON stated that I&As are reviewed by the interdisciplinary team (IDT) every Monday through Friday during the morning meeting. The IDT team included the DON, the Assistant Director of Nursing (ADON), Hall Supervisors, MDS Coordinator, Social Worker, CNA, and Dietary. When asked where the IDT discussion is documented, the DON stated the discussion is only documented on a regular notebook that only the DON and ADON have access to. The DON stated that nursing staff, not including CNAs, have access to the I&A reports. The DON stated the MDS Coordinator was responsible for updating the resident's care plan, that she was on the IDT team, and was verbally told how to update the resident's care plan and was not provided with the actual I&A report to review. The DON stated she reviewed the resident's care plan weekly to ensure interventions were transcribed accurately and there was no auditing process for accuracy of the care plan, and she was responsible for oversight of the accuracy of the care plans. The DON stated that CNAs were made aware of fall interventions by reviewing the resident's care plan. The DON stated the intervention of the lap buddy should have been removed from the resident's care plan on 04/16/2024 but was not due to an oversight. The DON also stated that she had just completed training and was made aware that acute illness could not be used as an intervention and the facility had stopped using that intervention, however, the facility did not go back and correct current care plans to discontinue acute illness as an intervention. The DON stated that behavior should not have been listed as an intervention because it was the cause of the fall and not an intervention. The DON stated staff educated was an appropriate intervention, however the care plan did not indicate what education was provided. The DON also verified that the resident did not have a wheelchair alarm and it should have been discontinued from the resident's care plan. The DON stated all falls are documented within Risk Management, which was not part of the resident's medical record and staff were instructed to put all notes related to the fall within the I&A in Risk Management. The DON stated staff should update the resident's care plan when an intervention needs to be discontinued.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | During an interview on 05/22/2024 at 3:32 PM, the Assistant Administrator (AA) stated the facility had a Falls Program that had not been put into place yet, which included for staff to complete a root cause analysis for falls. The AA stated that when a nurse completes an I&A within the electronic health record (EHR), there is a progress note section that should be copied over to the progress notes that is accessible within the EHR. When advised that the notes are only retained within the I&A and not transferred over to the EHR, the AA stated she was not aware the notes were not transferred over, however, they should be.<br><br>During an interview on 05/22/2024 at 4:46 PM, the Administrator stated she was aware that falls were an issue within the facility, and she expected her staff to update the resident's care plan timely and accurately and interventions should be removed from the care plan if they were no longer effective. The Administrator stated that all fall documentation should be on the I&A, which is not part of the resident's medical record, but should also be in the resident's progress notes to reflect why the facility was doing certain things, such as sending the resident to the hospital. The Administrator stated that the previous administration did not want any of the I&A information within the residents' progress notes.<br><br>2. A review of the Admission Record, indicated the facility admitted Resident #90 with diagnoses that included age related cognitive decline, muscle weakness, cognitive communication deficit, difficulty walking, dementia, and vertigo.<br><br>The Signification Change Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 04/17/2024, revealed Resident #90 had a Brief Interview for Mental Status (BIMS) score of 5 which indicated the resident had severe cognitive impairment. Further review of the MDS indicated the resident had two falls with no injury and one fall with major injury.<br><br>A review of Resident #90's care plan, initiated on 11/07/2023, revealed the resident was at risk for falls related to impaired balance, incontinence, and poor awareness of safety needs. Interventions included4 acute illness (with no context); family education (with no context); padded floor pad to open side of bed; grip around bathroom bar; staff education (with no context); staff changed intervention after requesting I&As (with no context); attempt grip socks at bedtime; anti-rollbacks to wheelchair, document all behaviors which are not usual for the resident and report to nurse/doctor; keep call light, water, and frequently used items in reach; monitor for changes in condition that may warrant increased supervision/assistance and notify the doctor; review information on falls and attempt to determine cause of falls; and staff to assist with performing ADL care as requested/needed.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | A review of Resident #90's Progress Notes from 09/18/2023 to 05/21/2024 did not include any notes directly related to any falls. On 01/30/2024 at 12:25 PM, the Director of Nursing (DON) indicated on a Skin only note that the resident had a fall resulting in an abrasion to their nose and first finger on the left hand. There was no additional information related to the fall. On 03/02/2024 at 11:04 AM, LPN #13 indicated on a Skin only note that the resident had a fall resulting in an abrasion to their nose and first finger on the left hand. This note was written verbatim to the DON's note on 01/30/2024 that included the same injury. On 03/28/2024 at 1:38 AM, RN #11 indicated the resident had a fall on 03/07/2024 at 2:20 AM in the resident's bathroom. There were no progress notes on or around the date of the actual fall. On 04/11/2024 at 5:45 PM, LPN #14 indicated she received a report from the local hospital stating the resident was being discharged back to the facility with the diagnosis of a compression fracture. There were no progress notes prior to the fracture to indicate the resident had a fall or was sent to the hospital. On 04/15/2024 at 5:57 AM, LPN #13 indicated on a Long Term Care Evaluation that the resident had a fall on 04/11/2024 while folding a blanket. On 04/17/2024 at 9:49 AM, the MDS Coordinator indicated the interdisciplinary team met related to the resident's falls and due to a decline in the resident's health from the falls, a significant change MDS had to be completed. By completing this, the facility believes that the decline will not resolve within a two-week period. On 04/26/2024 at 4:56 PM, the DON indicated on a Skin only note that the resident had a fall that resulted in a hematoma to the left side of the resident's forehead and the resident complained of pain when the area was touched. There were no other progress notes related to the fall or interventions put into place. On 05/12/2024 at 6:24 AM, RN #11 indicated on a monthly Long Term Care Evaluation that the resident had a fall on 04/24/2024. No other information was provided. Based on review of the progress notes, the resident had five falls.<br><br>A review of Resident #90's Incident and Accident reports since admission indicated the resident had a fall on 11/26/2024 (outside of the facility), 12/07/2024, 01/28/2024, 03/04/2024, 03/07/2024, 04/11/2024, 04/19/2024, and 04/24/2024. The total number of incident reports indicated the resident had eight falls since admission, one that resulted in a fractured back, and one resulted in a hematoma to the left side of their forehead.<br><br>A review of Fall Risk Evaluation indicated Resident #90 was evaluated for falls nine times since the resident was admitted . Seven of the evaluations indicated the type as Post Fall and all nine evaluations indicated the resident was At Risk for falls. Each Fall Risk Evaluation included level of consciousness, history of falls, ambulation status, vision status, balance, blood pressure, medication, change in mental status, and predisposing disease. The evaluations did not include any other information, such as interventions.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | During an interview on 05/21/2024 at 11:16 PM, the LPN #3 stated she was familiar with Resident #90 and was aware the resident had a fall that resulted in a fractured back. LPN #3 stated the resident does not use their call light because they forget to use it. LPN #3 stated after the resident had the fall that fractured the resident's back, the resident had an additional fall in the resident's bathroom. LPN #13 stated she was aware of the falls that occurred on 04/11/2024, 04/19/2024, and 04/24/2024. LPN #13 stated the resident had fall interventions that included non-skid strips in the resident's bathroom and then stated she needed to look at the resident's I&As to see what other fall interventions the resident had. LPN #13 stated she was trained to put the fall interventions in the I&A and that was the only place she knew to look for fall interventions. LPN #13 stated that CNAs do not have access to view the I&A and only nurses do. When asked how CNAs are made aware of the interventions, since they do not have access to the I&As, she stated the nurses verbally tell the CNAs in report and sometimes there are in-services completed. When asked if the interventions should also be in the resident's care plan, LPN #3 stated they should, but nurses do not do anything with the care plan and just review the I&As. LPN #3 verified that the MDS Coordinator updates the resident's care plan. LPN #3 stated when completing an I&A, the DON would typically tell the nurse what intervention to include, but if the previous intervention was successful, the nurse would just document interventions successful. LPN #3 stated the nurses only document within the I&A related to the resident's fall and not in the resident's progress notes.<br><br>During an interview on 05/22/2024 at 11:03 AM, LPN #9 stated she was familiar with Resident #90, that the resident had fallen a few times, was unfamiliar with the resident's fall interventions but would look in the resident's care plan for those.<br><br>During an interview on 05/22/2024 at 11:19 AM, LPN #15 stated she was familiar with Resident #90, that the resident had numerous falls in which one fall resulted in the resident fracturing their back and another resulted in bruising to the resident's face because the resident was unsteady on their feet. LPN #15 stated the resident had fall interventions of fall mats to the side of the resident's bed, non-skid socks, and shoes, and had been placed in a wheelchair after the fall resulting in the fractured back. LPN #15 stated the interventions should be in the resident's care plan. LPN #15 stated after a resident falls, the nurse completes an I&A, and the DON assists the nurse with putting a fall intervention on the I&A. Per LPN #15, all notes are to be completed within the I&A and not within the resident's progress notes. LPN #15 stated the MDS Coordinator was responsible for updating the resident's care plan and LPN #15 does not review the care plan for accuracy. At this time, LPN #15 reviewed Resident #90's care plan and stated the interventions of family and staff education should include what the family and staff were educated on. LPN #15 stated the care plan did not identify all interventions clearly in order for a certified nursing assistant (CNA) to understand.<br><br>During an interview on 05/22/2024 at 11:50 AM, CNA #10 stated she was familiar with Resident #90 and was aware the resident had a fall that resulted in a fractured back and one that resulted in a bruise to the resident's forehead. CNA #10 stated the resident needed a walker to ambulate [TRUNCATED] |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 045317 | A. Building<br>B. Wing | 05/22/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Wood-Lawn Heights | 2800 Neeley Street<br>Batesville, AR 72501 |

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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| F 0758<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46004<br><br>Based on observation, interview and record review, it was determined the facility failed to ensure PRN orders for psychotropic drugs were limited to 14 days, for two (Resident #9 and #70) of three residents reviewed for psychotropic medications. Specifically, the facility failed to include a duration for an as-needed (PRN) psychotropic medication. These failures affected residents who received psychotropic medications and increased the risk of unnecessary medication administration, adverse reactions, and unwanted side effects of the medications.<br><br>Findings included:<br><br>1. Review of an Admission Record dated [DATE] for Resident #9 reflected a [AGE] year-old female, admitted to the facility on [DATE] with diagnoses including dementia, and anxiety disorder.<br><br>Observation on [DATE] during initial rounds between 9:00 AM and 11:30 AM revealed Resident #9 in bed, sleeping.<br><br>Observation on [DATE] at approximately 9:00 am, when interviewed, Resident #9 did not answer questions appropriate to the conversation.<br><br>Review of an Annual MDS assessment dated [DATE] for Resident #9, Section I indicated a diagnosis of anxiety disorder.<br><br>Review of a Quarterly MDS assessment dated [DATE] for Resident #9 Section I indicated a diagnosis of anxiety disorder. Section C indicated Resident #9 had a BIMS of 3, indicating impaired cognitive function.<br><br>Review of a care plan for Resident #9 initiated on [DATE], and last revised on [DATE], reflected a focus of a risk of 'I have anti-anxiety medication use. Interventions included to .Administer anti-anxiety medications as ordered by physician .<br><br>Review of [DATE] Order Summary Report for Resident #9 reflected, Ativan tablet 0.5 mg one tablet every 4 hours as needed for anxiety, ordered on [DATE], and a start date of [DATE].<br><br>Review of the [DATE] MAR for Resident #9 reflected an order for Ativan 0.5 mg one tablet by mouth every four hours as needed for anxiety. The start date was [DATE].<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045317 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 05/22/2024 |
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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Wood-Lawn Heights | 2800 Neeley Street Batesville, AR 72501 |

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| F 0758<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Review of a Consultant Pharmacist Communication for Resident #9 dated [DATE] reflected, PRN Ativan 0. 5mg po q4H prn for Anxiety is prescribed for this resident. CMS Regulations require periodic re-evaluation of PRN Psychotropic Medications for possible discontinuation. Please review the use of PRN Ativan 0.5mg po q4H prn in this resident and consider discontinuation of therapy. If PRN Ativan prn is still Medically Necessary, please document the Clinical Rationale for continued use .[physician] Response. Do not discontinue medication. Patient continues to have episodes of packing up room & belongings to go back home looks for deceased husband gets distressed There was no duration indicated for the continued use of the psychotropic medication in the response.<br><br>2. Review of an Admission Record dated [DATE] for Resident #70 reflected a [AGE] year-old male, admitted to the facility on [DATE] with diagnoses including major depressive disorder.<br><br>Observation on [DATE] during initial rounds between 9:00 AM and 11:30 AM revealed Resident #70 was resting in bed, with eyes closed.<br><br>Observation on [DATE] at 10:54 AM revealed Resident #70 was in bed, sleeping.<br><br>Review of a Significant Change MDS assessment dated [DATE] for Resident #70, Section I indicated the box for a diagnosis of anxiety disorder, was not checked.<br><br>Review of a Quarterly MDS assessment dated [DATE] for Resident #70, Section I indicated the box for a diagnosis of anxiety disorder, was not checked.<br><br>Review of a care plan for Resident #70 revealed he was receiving Hospice Care, that initiated on [DATE]. An additional focus was 'I have psychotropic medication use, initiated on [DATE] and last revised on [DATE]. There was a focus of, I have anti-anxiety medication use, that was initiated on [DATE].<br><br>Review of [DATE] Order Summary Report for Resident #70 reflected, Admit to [hospice agency], dated [DATE]. There was an order for Buspirone 10 mg one tablet every 6 hours as needed for anxiety, ordered on [DATE].<br><br>Review of the [DATE] MAR for Resident #70 reflected an order for Buspirone 10 mg by mouth every 6 hours as needed for anxiety, ordered on [DATE]. There was no duration in the order.<br><br>Review of a Consultant Pharmacist Communication for Resident #70 dated [DATE] reflected, This resident has orders for Hospice. PRN Buspirone (Buspar) 10 mg po q6H prn for Anxiety is prescribed for this resident, which was ordered on [DATE]. PRN orders for Psychotropic Medications should be limited to 14 days unless Medically Necessary, per CMS Regulations. If PRN Psychotropic Medications are medically necessary beyond 14 days, the Clinical Rationale for continued use and Duration of use must be documented. Please review the use of PRN Buspirone 10mg po q6H prn in this resident and consider discontinuation of therapy. If PRN Buspirone prn is Medically Necessary, please document the Clinical Rationale for continued use and indicate the Duration of use .Response: Patient is on Hospice and Hospice did prescribe PRN med in the event it is needed for end-of-life support to help with anxiety & keep comfortable There was no duration indicated for the continued use of the psychotropic medication in the response.<br><br>(continued on next page) |

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| F 0758<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During an interview on [DATE] at 2:12 PM the DON was asked about PRN psychotropic medications for Resident #9 and Resident #70. She stated all PRN psychotropic medications should be discontinued after 14 days. She added Resident #70's PRN Buspar, for anxiety, was a hospice order.<br><br>Review of a policy titled, Pharmacy Services, dated ,d+[DATE] provided by the ADM as the current policy, reflected, .Compliance Guidelines: 1. The facility will provide pharmaceutical services to include procedures that assure the accurate acquiring, receiving, dispensing, and administering of all routine and emergency drugs and biologicals to meet the needs of each resident, are consistent with state and federal requirements, and reflect current standards of practice . |