STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045374	A. Building B. Wing	01/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Robinson Nursing and Rehabilitation Center LLC	519 Donovan Briley Blvd. North Little Rock, AR 72118

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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 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Encode each resident’s assessment data and transmit these data to the State within 7 days of assessment. 49596 Based on interview and record review, the facility failed to encode and transmit a Minimum Data Set (MDS) assessment following a resident ' s discharge in a timely manner for one (Resident #36) of one resident sampled for MDS encoding and transmission. The findings are: Per review of a Nsg-Discharge Summary Progress Note dated 9/13/2024 at 1:45 PM, Resident #36 was discharged from the facility on 9/13/2024. Review of Resident #36 ' s medical record on 1/9/2025 at 11:10 AM revealed the resident ' s MDS discharge assessment had not been completed or transmitted to the Centers for Medicare & Medicaid Services (CMS) as required. This observation took place 118 days following the resident ' s discharge from the facility. On 1/9/25 at 11:20 AM, the MDS Coordinator confirmed the MDS discharge assessment for Resident #36 was overdue, stating she is allowed seven days to enter the discharge information. She verified that Resident 36 ' s discharge was not entered in a timely manner.

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. 47916 Based on observation, record review, interview, and review of the Resident Assessment Instrument (RAI) manual, the facility failed to ensure the Minimum Data Set (MDS) accurately reflected section A1500, the preadmission screening and assessment resident record (PASRR), reflecting a serious mental illness and/or intellectual disability affecting 1 of 1 sampled (Resident #2) resident with a level II PASRR. Findings include: 1. Review of Medical Diagnosis revealed Resident #2 had diagnoses of paranoid schizophrenia, bipolar, and diabetes. a. The annual MDS with an Assessment Reference Date (ARD) of 02/23/2024, revealed a Brief Interview for Mental Status (BIMS) score of 14 (13-15 indicate cognitively intact). Section A1500 indicated 0 resident 2 does not have a level II PASRR. b. Review of Resident #2 ' s Care Plan, with a revision date of 06/19/2024, revealed Resident #2 had a level II PASRR. c. On 01/08/2025 at 10:54 AM, the Social Director (SD) provided Resident #2 ' s form 703 and 787 from 02/08/2022 and stated Resident #2 had a level II PASRR. d. On 01/08/2025 3:24 PM, the MDS Coordinator was asked Resident #2 ' s results on section A1500 of the MDS, and what guidance was used to code to the MDS. MDS Coordinator reviewed the Annual MDS with an ARD of 02/23/2024. The MDS Coordinator stated section 1500 was coded wrong with 0 indicating Resident #2 did not have a level II PASRR, and confirmed the RAI manual was used for guidance. When asked why it was important to code correctly to the MDS, the MDS Coordinator stated the MDS drives the residents care plan and can affect reimbursement. e. On 01/08/2025 at 3:30 PM, the MDS Coordinator was asked for a copy of the section of the RAI manual that was used to code section A1500. f. On 01/08/2025 at 3:35 PM, the MDS Coordinator provided section A1500, from the RAI manual showing code 1 for yes if resident has a PASRR level II.

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F 0656 Level of Harm - Minimal harm or potential for actual harm 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. 47916 Based on record review and interview, the facility failed to care plan oxygen to ensure 1of 1 sampled (Resident #37) resident received individualized, resident-centered care addressing interventions, treatment, and health care goals. Findings include: 1. Review of Medical Diagnosis revealed Resident #37 had diagnoses of atrial flutter, opioid dependency, and diabetes. a. The significant Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 09/04/2024, revealed a Brief Interview for Mental Status (BIMS) score of 15 (13-15 suggest cognitively intact). Section C0110, C1 indicated the resident was receiving supplemental oxygen. b. On 01/06/2025 at 3:06 PM, Resident #37 was observed receiving two liters of oxygen. c. On 01/07/2025 at 2:53 PM, Licensed Practical Nurse (LPN) #5 was asked for assistance finding where oxygen was addressed on Resident #37 ' s care plan. LPN #5 stated, I cannot find a care plan for oxygen. When asked if Resident #37 should have a care plan addressing oxygen, LPN #5 stated care plans are important because if someone checked they would know how much oxygen Resident #37 was supposed to be on, why Resident #37 was on oxygen, and what interventions to look for. LPN #5 stated Resident #37 was placed on oxygen in the summer, then confirmed 06/03/2024, after a chest x-ray for shortness of breath was verified from the order summary. d. During an interview on 01/08/25 at 10:50 AM, the Administrator was asked if a resident was on oxygen that has been documented on the MDS, should it also be care planned. The Administrator revealed that oxygen should be care planned because the care plan directs staff on resident care. Administrator was asked to provide a care plan policy. e. The Consultant provided a letter indicating the facility does not have a care plan policy, but they do follow the Resident Assessment Instrument (RAI) manual. f. On 01/09/2025 at 9:16 AM, MDS Coordinator provided Chapter 4: Care Area Assessment (CAA) Process and Care Planning, from the RAI manual revealing assessment results must accurately reflect a residents need to develop a comprehensive care plan. The RAI process considers the efforts of the health care team to trigger areas of concern that may warrant interventions to prevent further decline. The MDS Coordinator noted that since there was not an order for oxygen, the trigger for care planning was overlooked. She confirmed that oxygen was documented on the MDS and should have been care planned.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. 49596 Based on observation, interview, and record review, the facility failed to ensure personal hygiene, as related to proper nail care, was not provided to residents who were dependent on nail care for 2 (Residents #83 and #87) of 2 residents reviewed for activities of daily living (ADL) care. The findings include: 1. A. Review of Resident #83 ' s Care Plan identified: i. Resident needs secured/special care neighborhood due to behaviors/psychosocial/dementia/ other psychiatric issues, initiated: 07/22/2024. ii. Resident has an ADL self-care performance deficit, initiated: 02/27/2024. iii. Resident has potential/actual impairment to skin integrity r/t (related to) fragile skin, incontinence of bowel and bladder, Dx (Diagnoses) of: Dementia, schizophrenia, and iron deficiency anemia. Initiated: 10/15/2024. B. Review of Resident #83 ' s Minimum Data Set (MDS) dated Dec. 5, 2024, reflects resident had a Brief Interview for Mental Status (BIMS) score of 00 which indicated Resident #83 had severe cognitive impairment. C. MDS dated Dec. 5, 2024, reflected Resident #83 to have diagnoses of: Dementia, anxiety disorder, psychotic disorder, post-traumatic stress disorder. 2. A. Review of Resident #87 ' s Care Plan identified: i. Resident #87 needs secured/special care neighborhood due to behaviors/psychosocial/Dementia/wandering/elopement risk; Initiated: 06/17/2024. ii. Resident #87 had an ADL self-care performance deficit r/t Dementia; Initiated: 06/04/2024. iii. Resident #87 had impaired cognitive function/dementia or impaired thought processes as evidenced by BIMS score; Initiated: 06/13/2024. iv. Resident #87 had potential to be physically aggressive: hitting, kicking, pushing, pinching, scratching, etc. related to: Dementia; Initiated: 06/04/2024. B. Review of Resident #87 ' s MDS dated Dec. 3, 2024, reflected resident had a Brief Interview for Mental Status (BIMS) score of 00 which indicated Resident #87 had severe cognitive impairment. C. Review of a Physician ' s Order dated 01/06/25, identified Resident #87 to have diagnosis of: Alzheimer's Disease Vascular Dementia, and Behavioral Disturbance. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. A. On 01/6/24 at 10:30 AM, Resident #83 ' s nails were observed to be long and jagged with dark brown substance underneath the nails. B. 01/08/25 at 3:52 PM, Resident #83 ' s nails observed to be long and jagged with dark brown substance underneath the nails. 4. A. On 01/06/25 at 9:45 AM, Surveyor observed Resident #87 walking down the hallway. Resident ' s fingernails were observed to have a dark brown substance underneath the nails. B. On 01/06/24 at 10:28 AM, Surveyor observed resident #87 fingernails had a dark brown substance underneath the nails and a brown substance was on top of the nails. 5. A. On 01/09/25 at 9:20 AM, CNA #12 said the brown substance under fingernails could be food or fecal matter. CNA #12 stated if it were fecal matter, it could have something like clostridium difficile or hepatitis in it, or any illness the resident might have in it. It could be transferred to staff or other residents. CNA #12 stated The resident could get it from digging, but we don ' t really have any diggers, or from toileting. Fecal matter carries a lot of things. B. On 01/09/25 at 9:30 AM, CNA #10 said the brown substance under fingernails could be fecal matter from digging because we have a lot that dig. It could have germs in it like clostridium difficile. 6. On 1/9/25 at 10:20 AM, the Nurse Consultant stated the facility does not have a policy for nail care.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 37634 Based on observations, interviews, record review, it was determined that the facility failed to ensure 1 (Resident #11) of 1 sampled resident ' s wheelchair was in good working condition. The findings are: A review of an Order Summary Report indicated that Resident #11 had diagnoses of type 2 diabetes and restless legs syndrome, and a physician ' s order for Apixaban, an anticoagulant medication used to treat and prevent blood clots, with common side effects that include bleeding. The annual Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 12/05/2024, revealed Resident #11 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident was cognitively intact. The MDS revealed Resident #11 used a wheelchair for mobility. Review of Resident #11's Care Plan, revised 11/10/2024, revealed the resident had potential for skin tear and bruising related to fragile skin, and long-term use of anticoagulants. On 1/06/25 at 11:05 AM, Resident #11 indicated that the wheelchair was digging into her legs. She indicated that when she moves around in her chair the wheelchair scrapes her leg. She indicated that she has informed the staff about the wheelchair, and they indicated that they don't know why she hasn't received a wheelchair. Resident #11 indicated that she sits up in her wheelchair most of the day. Resident #11 raised up her left leg and the cap was missing from the frame of the wheelchair below the seat. The frame was pressing into Resident #11's leg. On 1/08/25 at 1:54 PM, the Administrator indicated that wheelchairs are inspected very shift. The Administrator indicated that Resident #1 ' s wheelchair should be in good repair. He indicated that that he wasn't for sure why a new wheelchair hadn't been ordered already. On 1/08/25 at 1:58 PM, the MDS Coordinator indicated that the lead CNA (Certified Nurse Aide) informed her that Resident #11 said her wheelchair was too small, and it was rubbing the back of her legs. On 1/09/25 at 9:44 AM, the Lead CNA indicated that wheelchairs are inspected nightly, and on shower days which are on Mondays, Wednesdays, and Fridays. The lead CNA indicated that the Administrator informed him about Resident #11's wheelchair yesterday. On 1/09/25 at 9:50 AM, the MDS Coordinator indicated that a skin assessment was completed on Resident #11 after she received her new wheelchair yesterday. She indicated that Resident #11 did not observe any damage to Resident #11 ' s skin. On 1/09/2025 at 10:30 AM, the Administrator indicated that the facility did not have a policy for wheelchairs or equipment.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. 49596 Based on observation, record review, interview, and facility policy review the facility failed to ensure a resident on 2 liters of oxygen had a physician ' s order for oxygen therapy to ensure resident received the appropriate and safe dosage of oxygen therapy affecting 1 (Resident #37) of 1 resident sampled for oxygen therapy. Findings include: 1.Review of Medical Diagnosis revealed Resident #37 had diagnoses of atrial flutter, opioid dependency, and diabetes. a. The significant change Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 09/04/2024, revealed a Brief Interview for Mental Status (BIMS) score of 15(13-15 suggest cognitively intact). MDS section C0110, C1 indicated Resident #37 was receiving supplemental oxygen. b. Review of a policy titled Oxygen Safety, with a revision date 11/22/2016, revealed that oxygen therapy is administered only upon a written order of a licensed physician. c. On 01/06/2025 at 3:06 PM, Resident #37 was observed on 2 liters of oxygen via nasal cannula (LNC). d. On 01/07/2025 at 2:22 PM, Resident #37 ' s oxygen concentrator was set on 2 LNC, and tubing was dated 01/06/2025. e. On 01/07/2025 at 2:23 PM, during an interview with Licensed Practical Nurse (LPN) #5 at Resident #37's bedside, LPN #5 was asked to check the oxygen concentrator, and LPN #5 verified it was set on 2 liters. When asked why the resident was on oxygen, LPN #5 replied Resident #37 gets short of breath. f. On 01/07/2025 at 2:53 PM, LPN #5 was asked for assistance findings an oxygen order for Resident #37. LPN #5 checked for orders and revealed that she could not find oxygen orders. LPN #5 looked at the order summary and stated, We did a chest Xray on 06/03/2024, and put Resident #5 on oxygen at that time, but I am not findings an order. When asked why Resident #37 should have an order for oxygen, LPN #5 revealed that residents on oxygen require a physician ' s order directing staff on the appropriate dosage. g. On 01/08/2025 10:50 AM, the Administrator was asked if residents receiving oxygen therapy are expected to have an order for oxygen, and who was responsible for checking for orders. The Administrator revealed that residents with oxygen require an order because it is considered a medication, and confirmed nursing staff are responsible, but because there was not an order it did not appear on the Medication Administration Record (MAR) for documentation.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 03508 Based on observation, interview, and facility policy review, the facility failed to ensure dietary staff washed their hands before they handled clean equipment or food, and manufacture specification was followed for 2 of 2 meals observed. The findings are: 1. On 01/07/25 at 1:59 PM, Dietary Aide (DA) #1 picked up the water hose with his bare hand, used it to spray leftover food from inside of the dishes, contaminating his hands. DA #1 placed the dirty dishes in the dirty racks and pushed the racks into the dish washing machine to wash. After the dishes stopped washing, he moved to the clean side of the dishwasher area and picked up a clean blade and placed it inside the blender to be used in pureeing food items to be served to residents who required pureed diet and or mechanical soft diets without performing hand hygiene. DA #1 was interviewed and asked what he should have done after touching dirty objects or before handling clean equipment. He stated he should have washed his hands. 2. On 01/07/25 at 4:02 PM, Dietary [NAME] (DC) #2 removed a pan of cooked turkey from the oven and placed it on the counter, contaminating her hands. Without washing her hands, she picked up pans to be used in transferring pureed food items to be served to residents who required pureed diet for the supper meal and placed them on the counter with her fingers inside the pans. DC #2 was interviewed and was asked what she should have done after touching dirty objects and before handling clean equipment; she stated she should have washed her hands. 3. On 010/7/25 at 4:12 PM, DC #2 untied the bread bag, and placed it on the counter without washing her hands. DC #2 removed a glove from the glove box, contaminating the glove, then used the contaminated gloved hand to pick up a clean blade and attached it to the base of the blender, to be used in pureeing food items to be served to residents who required a pureed diet. 4. On 01/07/25 at 4:36 PM, DA #1 walked into the clean area of the dish washing machine from the dining room, contaminating his hands after touching the knob to open the door. Without washing his hands, Dietary aide #1 picked up napkins and placed them on the cart. He also picked up utensils from the area that would go into the resident's mouth and placed them on individual napkins, wrapping them for residents to use during their meals. When asked what the residents use the napkins for, he stated that they use them to wipe their mouths while eating. DA #1 was interviewed and was asked what he should have done after touching dirty objects and before handling clean equipment; he stated he should have washed his hands. 5. On 01/08/25 at 8:31 AM, Dietary aide (DA) #3 removed his hands from his pocket, contaminating his hands. Without washing his hands, DA #3 picked up clean bowls and plates and stacked them up on the rack to be used in positioning food items to be served to the residents at the lunch meal. DA #3 was interviewed and was asked what he should have done after touching dirty objects and before handling clean equipment; he stated he should have washed his hands. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	6. On 01/08/25 at 8:35 AM, Dietary [NAME] (DC) #4 opened bags of shredded cabbage, shredded carrots, and shredded red cabbage and emptied them into a bowl, opened a container of mayonnaise poured some on top of the shredded green cabbage, shredded red cabbage and shredded carrots, then placed gloves on his hands, contaminating the gloves. Without changing gloves and washing his hands, DC #4 then used his contaminated gloved hands to mix cabbages and carrots to be served to the residents for lunch meal. DC #4 was interviewed and was asked what he should have done after touching dirty objects and before handling clean equipment; he stated he should have washed his hands. 7. On 01/08/25 8:50 AM, an opened bottle of lemon juice was on a shelf above the food preparation counter. The manufacturer specifications on the bottle indicated to refrigerate after opening. DC #4 was interviewed and was asked what the lemon juice was used for; he stated kitchen staff use it to clean the grill and also use it when a recipe calls for it. At 11:40 AM, DC #2 was interviewed and was asked what the lemon juice was used for; she stated kitchen staff use it to clean the grill and also use it when a recipe calls for it. On 01/09/25 at 10:05 AM, Dietary Manager (DM) was interviewed and was asked what the lemon juice was used for; she stated kitchen staff use it to clean the grill and also use it when a recipe calls for it. 8. A review of facility policy titled, Handwashing and Glove Usage in Food service, initiated 2016, provided by the Dietary Manager on 01/08/2025, indicated, food handlers should wash their hands before starting work, after touching dirty dishes or clothing and after touching anything else such as dirty equipment.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49596 Based on observations and interviews, the facility failed to ensure the residents resided in a safe, functional, and comfortable environment as evidenced by two (rooms [ROOM NUMBERS]) exhibiting stained, soiled privacy curtains and damaged chairs. The findings are: 1. During facility rounds on 1/6/25 at 10:18 AM, the Surveyor observed the privacy curtains in Rooms 104 (Resident #38 was a resident in this room) and room [ROOM NUMBER] (Resident #82 resided in this room) had dark brown stains in several areas. The substance on the curtain in room [ROOM NUMBER] had dark brown lumps in it. The white bedside chair in room [ROOM NUMBER] had the vinyl peeled off the top corner of the chair, exposing the foam and fabric underneath. The white chair in room [ROOM NUMBER] had a large hole, approximately 2 in diameter, on the right arm of the chair. The vinyl edges of the hole were sharp and rough to the touch. 2. During facility rounds on 1/9/25 at 10:10 AM, the Surveyor observed the dark brown stains on privacy curtains in rooms [ROOM NUMBERS] remained as found in previous observation. The privacy curtain in room [ROOM NUMBER] continued to have a dark brown lump of substance on it. The white bedside chair in room [ROOM NUMBER] had the vinyl finish peeled off the top corner of the chair, exposing the foam fabric underneath. The vinyl edges of the hole were rough to touch. The white chair in room [ROOM NUMBER] had a large hole, approximately 2 in diameter, on the right arm of the chair. The vinyl edges of the hole were sharp and rough to the touch. 3. During an interview on 1/9/25 at 9:20 AM, Certified Nursing Aide (CNA) #12 said the dark stains on the curtain in room [ROOM NUMBER] were from a milkshake the resident had thrown about a week previous, stating, But if it is not that and is fecal matter it can be dangerous to staff and resident because fecal matter has germs like C-Diff (clostridium difficile) or hepatitis and these make you sick. CNA #12 said the missing vinyl on the chair has the potential to be harmful to the resident because it is sharp, and it can have germs in it. 4. On 1/9/25 at 9:30 AM, CNA #10 said the substance and stains on the curtain in room [ROOM NUMBER] could be feces, and it could be harmful to a resident or staff because feces can have any sickness the resident might have and it can transfer to anyone who touches it, like C-diff. CNA #10 said the tear on the chair has the potential to be harmful to the resident because it is sharp, and the resident could sustain a skin tear and get the germs in it. 5. On 01/09/25 at 10:30 AM, the Nurse Consultant said they do not have a policy on furniture replacement.