| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 045428 | A. Building<br>B. Wing | 11/07/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Edgewood Health and Rehab | 1393 E Don Tyson Parkway<br>Springdale, AR 72764 |

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| F 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.<br><br>50923<br><br>Based on record review, and interviews, the facility failed to report an incident of resident self-inflicted injury for 1 (Resident #89) of 1 resident reviewed for self-inflicted injury which was unobserved and required transfer to the hospital for examination and/or treatment.<br><br>The findings are:<br><br>Upon review of Resident #89 ' s Admission Record, the facility admitted Resident #89 on 10/11/2023 with diagnoses of Chronic Obstructive Pulmonary Disease (COPD) and generalized muscle weakness. Resident #89 also had unspecified depression, anxiety, and dementia.<br><br>The Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 07/04/2024 revealed Resident #89 had a Brief Interview for Mental Status (BIMS) score of 15 (13-15 suggest cognition intact). Resident #89 required supervision with ambulation. The MDS reflected Resident #89 used a walker and at times, a manual wheelchair for mobility.<br><br>Per interview with Licensed Practical Nurse #5, On 08/09/2024 at approximately 5:30 PM, Resident #89 told Licensed Practical Nurse (LPN) #5 they would go to the dining room after finishing in the bathroom. At approximately 6:00 PM, LPN #5 noticed Resident #89 ' s dinner tray was still uncovered in the dining area and decided to take the tray to the resident ' s room and check on Resident #89. LPN #5 and CNA #4 went to the resident ' s room and found Resident #89 in the bathroom floor. Blood was noted on the floor, and Resident #89 was not moving and laying on the left side. LPN #5 turned Resident #89 over to assess them and noticed a sharp object in the left side of the resident ' s neck. LPN #5 stated Resident #89 was attempting to remove and/or advance the sharp object lodged in the left side of their neck, so LPN #5 and CNA #4 continued to stabilize the object and secure the resident ' s hands to prevent further injury until first responders arrived. Emergency services were notified and arrived at the facility shortly after the discovery. They transported Resident #89 to a local hospital where the resident was treated for the puncture wound. A note was found in a lockbox on the bathroom floor from Resident #89 to their family that stated, I am sorry [family member]. You have done so much for me, and I love you very much. Goodbye! The hospital staff reported after surgery, Resident #89 continued to attempt to remove the tracheostomy (surgically created airway) while in the hospital and had to be restrained. Resident #89 did survive the incident and was released from the hospital 08/22/2024, but the family decided not to have the resident return to the facility and moved the resident to another state, to be closer to family.<br><br>(continued on next page) |



| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|

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| F 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview with the administrator on 11/05/2024 at 2:30 PM, regarding the incident, Administrator was asked if the facility reported this incident and she responded, No, we completed an incident and accident report with witness statements. We were all shocked. Through our investigation after the incident, staff determined there were no signs to warn of a suicide attempt, or worsening of [Resident #89 ' s] depression. Staff all agreed [Resident #89] often participated in activities, sang, danced, went out with family, and was smiling, not withdrawn in any way. Social Services Director (SSD) had a good rapport with Resident #89, and their family, and talked with them often. Resident #89 ' s depression screenings did not indicate a change or worsening of depression, and the resident did not let any of us know about feelings of sadness. When asked why this was not reported, Administrator stated, We knew what happened, a note was left and it did not involve anyone else, so we thought it was not something that needed to be reported. When asked about the follow up appointments with APRN #7 to address Resident #89 ' s anxiety and depression, the Administrator stated, I am not sure, but I know [Resident #89] did not like to be seen over telehealth. The facility offered other options, but the resident ' s brother transported Resident #89 to all appointments, and he was not aware the resident had depression, often called resident #89 a hypochondriac so that might have prevented the resident from confiding in family to go to outside appointments. We also were setting up in-house appointments to address behavioral health for any residents that need it, and that service was also offered to [Resident #89].<br><br>During an interview with SSD on 11/6/2024, at approximately 11:00 am, she confirmed Resident #89 was consistent with answers on the depression screening, and stated she thought the resident would have opened up to her about any worsening symptoms due to their rapport and frequent interactions/conversations.<br><br>During an interview with APRN #6 on 11/6/2024, she stated Resident #89 had been scheduled for appointments to follow up on depression and anxiety with APRN #7 via tele-health on 05/15/2024 at 2:15 PM, 06/10/2024 2:45 PM, and 07/17/2024 at 10:45. APRN #6 stated she was unsure of why these appointments were not completed, but Resident #89 had complained to her that she did not like appointments not in person and she was thinking at least one of these appointments, the resident refused per facility staff. APRN #6 also stated, The depression was not a huge focus in their visits, but Resident #89 did complain of pain in different areas, and worsening anxiety when pain was worse. Each time the resident complained of a different area of pain, the complaint was addressed, and resident was seen by several specialists to address the issues.<br><br>During an interview with APRN #7 on 11/6/2024, she confirmed Resident #89 had follow up appointments scheduled but were not kept, meaning the resident/facility did not log onto the portal to complete the appointment via telehealth. Appointments were rescheduled each time they were missed, and the current medications were continued.<br><br>Upon review of a Social Services Assessment, completed by the SSD, dated 7/5/2024, Resident #89 ' s Patient Health Questionnaire (PHQ-9) remained at a 4 (0-4 indicates minimal or no depression). This was unchanged from previous PHQ-9 scores previously completed by SSD. |

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| F 0727<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis.<br><br>42016<br><br>Based on observations, interviews, and document reviews, the facility failed to ensure a Registered Nurse (RN) worked at least 8 consecutive hours a day, for 7 days a week, and the Director of Nursing (DON) did not serve as the RN in the facility. This failed practice had the potential to affect all residents residing in the facility. The facility census was 84.<br><br>Findings included:<br><br>A review of an undated document, titled Job Description Charge Nurse/Shift Supervisor, revealed the primary purpose of the position was to direct nursing care that included: participation in surveys, admit, transfer, and discharge residents, administering medications, arranging diagnostic services, consulting with physician for resident care and treatment, ensuring resident treatments are performed, evaluate residents physical and emotional status, provide catheterization, tube feedings, dressing application/changes, massages, range of motion exercises, obtaining lab specimens, and checking residents, unable to utilize the call light, frequently, and supervise nursing activities performed by nursing assistants. The supervision must be in accordance with current federal, state, and local standards, guidelines, and regulations governing the facility.<br><br>A review of an undated document, titled Job Description Assistant Director of Nursing, revealed the primary purpose of the position was to direct the operation of the nursing department in accordance with current federal, state, and local standards, guidelines, and regulations governing the facility. Responsibilities of the ADON included act as Director of Nursing Services in the absence, or unavailability of the DON, directing nursing services, ensuring nursing services follow respective job descriptions and assist with planning resident care.<br><br>A review of an undated document, titled Job Description Director of Nursing, revealed the primary purpose of the position was to plan, organize, develop, and direct the operation of the nursing department in accordance with current federal, state, and local standards, guidelines, and regulations governing the facility.<br><br>A review of the staffing schedule dated October 2024 through November 2024, revealed an as needed (PRN) RN on the schedule 7 days in October, and 7 days in November. The Assistant Director of Nursing (ADON) stated there was one RN scheduled for weekends.<br><br>A review of the clock in times for weekend RN coverage from 10/05/2024 through 11/02/2024,<br><br>revealed an RN was in the facility each day.<br><br>A review of the Direct Care Daily Staffing report revealed no RN coverage on 10/01/2024 through 10/03/2024, 10/07/2024 through 10/10/2024, 10/14/2024 through 10/17/2024, 10/19/2024, 10/21/2024 through 10/24/2024, 10/28/2024 through 10/31/2024, and 11/04/2024 through 11/05/2024.<br><br>(continued on next page) |

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| F 0727<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During an interview on 11/06/2024 at 9:34 AM, Human Resources (HR), stated the Director of Nursing (DON) and the Assistant Director of Nursing (ADON) were not counted on Direct Care Daily Staffing sheets, and they were the RN in the building on those days (referring to the dates with no coverage noted).<br><br>A review of clock in times provided by HR, revealed RN coverage on 10/19/2024 was done by the nurse consultant. HR stated Nurse Consultant worked on the floor as a nurse supervisor, when needed. RN coverage for 10/01/2024 through 10/03/2024, 10/07/2024 through 10/10/2024, 10/14/2024 through 10/17/2024, 10/19/2024, 10/21/2024, 10/24/2024, 10/28/2024 through 10/31/2024, and 11/04/2024 through 11/05/2024 was done by ADON. HR stated ADON was covering for DON who was on vacation.<br><br>During an interview on 11/06/2024 at 10:53 AM, the ADON stated the DON was on vacation until Monday (11/11/2024) and he was acting DON. The ADON stated he was not able to work on the floor and do the RN hours but believed he was able to be the acting DON.<br><br>During an interview on 11/06/2024 at 4:16 PM, the Administrator stated DON was on vacation and the position was being covered by ADON. The Administrator stated the facility did not have a staffing waiver in place, and the census was currently 83. The Administrator was not aware of any rule not allowing the DON or ADON to count in the 8 consecutive RN hours. |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide and implement an infection prevention and control program.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42016<br><br>50923<br><br>Based on observations, interviews, and facility policy review, the facility failed to ensure staff performed hand hygiene during meal service. Specifically, staff failed to perform hand hygiene between serving resident trays, prior to entering or leaving resident rooms on 1 (300) hall of 1 hall observed during meal service; and failed to ensure hand hygiene was performed during perineal care with a brief change for 1 (Resident #12) of 21 sampled residents. The facility also failed to initiate Enhanced Barrier Precaution (EBP) for 1 (Resident #34) of 1 resident reviewed for enhanced barrier precautions.<br><br>Findings included:<br><br>A review of a facility policy titled, Handwashing/Hand Hygiene, revised 10/2023 revealed, the facility trained and expected all employees to follow the policy on hand hygiene, as the facility considered hand hygiene the primary means of preventing the spread of healthcare-associated infections. Hand hygiene was to be performed, c. after contact with . body fluids .d. after touching a resident; e. after touching the resident's environment; f. before moving from work on a soiled body site to a clean body site on the same resident.<br><br>During an observation on 11/04/2024 at 12:38 PM, Certified Nursing Assistant (CNA) #1 removed a tray from the insulated cart, containing meal trays for residents on 300-Hall, and entered room [ROOM NUMBER], placed the meal tray on the B-bed overbed table and exited the room. CNA #1 placed the lid, that covered the plate, on the handrail, with the handle facing away from the wall. CNA #1 then placed the meal ticket above name plate, sliding it between the wall and nameplate. No hand hygiene was performed. CNA #1 returned to the insulated cart, removed a meal tray, and entered room [ROOM NUMBER]. CNA #1 placed the meal tray on the overbed table of A-bed and exited the room. CNA #1 placed the lid, that covered the plate, on the handrail, with the handle facing away from the wall. CNA #1 then placed the meal ticket above name plate, sliding it between the wall and nameplate. No hand hygiene was performed. CNA #1 returned to the insulated cart.<br><br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | At 12:40 PM, CNA #1 removed a tray from the insulted cart and entered room [ROOM NUMBER]. CNA #1 placed the meal tray on the overbed table of B-bed and exited the room. CNA #1 placed the lid, that covered the plate, on the handrail, with the handle facing away from the wall. CNA #1 then placed the meal ticket above name plate, sliding it between the wall and nameplate. No hand hygiene was performed. Human Resources (HR) walked onto 300-hall and advised CNA #1 to sanitize their hands. CNA #1 entered room [ROOM NUMBER] and sanitized their hands. CNA #1 returned to the insulated cart, removed a meal tray and entered room [ROOM NUMBER] and placed the meal tray on an overbed table of A-bed and exited the room. CNA #1 placed the lid, that covered the plate, on the handrail, with the handle facing away from the wall. CNA #1 then placed the meal ticket above name plate, sliding it between the wall and nameplate. No hand hygiene was performed. CNA #1 returned to the insulated cart. CNA #1 moved the insulated meal cart down the hall to room [ROOM NUMBER], opened the door of the cart and removed a tray and entered room [ROOM NUMBER], and placed the tray on the overbed table of A-bed and exited the room. CNA #1 placed the lid, that covered the plate, on the handrail, with the handle facing away from the wall. CNA #1 then placed the meal ticket above name plate, sliding it between the wall and nameplate. No hand hygiene was performed.<br><br>During an interview on 11/04/2024 at 12:44 PM, CNA #1 stated hands should be sanitized or washed after every tray. CNA #1 stated they washed their hands in the resident's bathroom. The surveyor stated CNA #1 was observed entering resident's rooms, placing trays on residents over bed tables, exiting the rooms and placing the lids on the handrails and meal tickets above the name plates, and CNA #1 did not enter the bathroom in any of the rooms or use the sanitizer, until being told to do so, then entered room [ROOM NUMBER] and used hand sanitizer. CNA #1 admitted they did not wash or sanitize their hands in any of the rooms until being told to do so and should have sanitized between trays to prevent the spread of infection to residents.<br><br>During an interview on 11/04/2024 at 2:04 PM, the Assistant Director of Nursing (ADON) stated he was the infection preventionist, and that staff knew hand hygiene was to be performed between each tray that was served, and before leaving a resident's room.<br><br>A review of the Admission Record, indicated Resident #12 was admitted with diagnoses that included a disorder that caused inflammation, muscle pain and stiffness of shoulders and hips; body pain and tiredness; difficulty walking; and chronic kidney disease.<br><br>A review of Resident #12 ' s care plan, initiated on 10/01/2024, indicated Resident #12 had an Activity of Daily Living (ADL) deficit related to weakness and pain, and required 1 to 2 staff for bed mobility, was not toileted, had bladder and bowel incontinence, and required Enhanced Barrier Precautions (EBP). Interventions included, providing perineal care after each incontinent episode, wearing gloves and a gown for high-contact care activities.<br><br>A review of the quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 09/30/2024, revealed Resident #12 had a Brief Interview for Mental Status, (BIMS) score of 15, indicating resident was cognitively intact. Resident #12 used a wheelchair for ambulation; required substantial to maximal assistance for toileting, bathing, dressing and rolling side to side in bed; required setup/cleanup assistance with eating and personal hygiene; and was always incontinent of bladder and bowel.<br><br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | A review of Resident #12 ' s Order Summary, with an order date of 10/31/2024, indicated barrier cream was to be applied to buttocks two times daily; an antibiotic to be injected into the muscle daily through 11/11/2024 for a urinary tract infection (UTI); and EBP was to be used every shift.<br><br>A review of Resident #12 ' s Order Summary, with an order date of 11/02/2024, indicated a urine sample was to be obtained immediately and sent for testing that included a culture and sensitivity, a test to determine the type of bacteria and the medication that would be effective in killing or stopping the bacteria from multiplying.<br><br>A review of Resident #12 ' Lab Results Report, dated 11/04/2024 indicated the bacteria was Escherichia coli, with a sensitivity to antibiotics that included a third-generation cephalosporin.<br><br>During an observation on 11/06/2024 at 10:23 AM, CNA #2 entered Resident #12's room to perform perineal care and a brief change. CNA #2 used hand sanitizer and donned EBP that included a gown and gloves. CNA #2 closed the resident's door, pulled the privacy curtain, lowered the head of the bed (HOB), removed a blanket and sheet covering Resident #12, pulled resident's pants down, unfastened the brief and tucked it between the resident's legs. CNA #2 used adult wipes to clean Resident #12's suprapubic area, groin, and genitalia. CNA #2 assisted Resident #12 onto their right side. CNA #2 pushed the soiled brief under Resident #12 and placed a clean brief, outstretched and half under resident. CNA #2 used 2 adult wipes and cleaned Resident #12's genitalia, and 1 wipe to clean each buttock. CNA #2 applied barrier cream containing Vitamin A, D, E, Aloe, and Zinc. CNA #12 then used 1 adult wipe to clean their gloves. CNA #2 then assisted Resident #12 onto their left side, removed the soiled brief, adjusted the draw sheet and pulled the clean brief under the resident, assisted Resident #12 onto their right side and adjusted the draw sheet and clean brief. Resident #12 rolled onto their back and CNA#2 pulled the brief up between Resident #12's legs and fastened the brief in place using the attached hook and loop fasteners. CNA #2 pulled Resident #12's pants up, adjusted the resident's shirt and pants, covered Resident #12 with the sheet and blanket, raised the HOB with the bed controller, placed the call light in reach of the resident, and moved overbed table in reach of resident. CNA #2 removed the trash bag from the trashcan, opened the privacy curtain, removed the gown and gloves, and sanitized their hands. CNA #2 did not remove the soiled gloves or perform hand hygiene during the brief change process.<br><br>During an interview on 11/06/2024 at 10:36 AM, CNA #2 stated they were not allowed to remove the gloves after entering the resident's room because the resident was on EBP due to a wound. CNA #2 stated the gloves were cleaned but not changed and hand sanitation was not done because it would have been unsanitary to remove gloves, sanitize, and put on clean gloves in a room where EBP was used. CNA #2 stated touching the clean brief, resident's pants, bedding, call light, bed control, and curtain, was not sanitary.<br><br>During an interview on 11/06/2024 at 10:53 AM, the ADON stated Resident # 12 had issues with UTI's, and was just given antibiotics after a culture was received indicating a bacterial infection. The ADON stated gloves should be changed when they became soiled, and hands should be sanitized between glove changes. The ADON stated gloves would be considered soiled when cleaning a resident using a wipe.<br><br>During an interview on 11/06/2024 at 4:16 PM, the Administrator stated staff were expected to follow the facility's hand hygiene policy.<br><br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Review of an Admission Record indicated the facility admitted Resident #34 on 10/01/2024 with admitting diagnoses of a post-surgical right hip fracture repair and orthopedic aftercare.<br><br>Review of the quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 10/04/2024, revealed Resident #34 had a Brief Interview for Mental Status (BIMS) score of 11, which indicated the resident had moderate cognitive impairment. In section GG, it stated Resident #34 ambulated with assistance of a walker and required partial to moderate assistance with their Activities of Daily Living (ADLs).<br><br>On 11/04/24 at 12:30 PM, Resident #34 was observed to have a pressure ulcer to the right heel and a pressure ulcer to the sacrum. At the time of the observation, no sign or notification for EBP was seen, and no Personal Protective Equipment (PPE) was seen in Resident #34's room.<br><br>A review of Resident #34's Clinical Physician's Orders, indicated the resident had a treatment order for an unstageable pressure ulcer to the right heel, and a stage II pressure ulcer to the sacrum. There were no orders for EBP for Resident #34.<br><br>On 11/05/24 at 8:25 AM, the Surveyor interviewed LPN #3 regarding Resident #34. LPN#3 stated the floor nurses are responsible for completing ordered wound care treatments for their residents. She confirmed this resident has two pressure ulcers, one unstageable to the right heel and a stage II to the sacrum. She also confirmed Resident #34 should have been on Enhanced Barrier Precautions (EBP), but it was not in place at this time.<br><br>A review of Resident #34's care plan, revised on 11/05/2024, included the implementation of enhanced barrier precautions, however; it stated this was initiated on 10/28/2024. The care plan history in the facility's electronic medical records showed enhanced barrier precautions along with the interventions that were initiated on 11/05/2024 following the interview with LPN #3.<br><br>On 11/07/24 at 10:27 AM, Surveyor interviewed ADON regarding EBP and Resident #34. He confirmed Resident #34 was currently receiving treatment for an unstageable pressure ulcer to the right heel, and a stage II pressure ulcer to the sacrum, and should have been on EBP. During the interview, ADON and Surveyor reviewed Resident #34's Clinical Physicians Orders. He confirmed there was not an order prior to the surveyor discussing the findings with staff.<br><br>Upon review of a facility policy titled Enhanced Barrier Precautions with a date of August 2022, the policy stated in number 5: Enhanced Barrier Precautions (EBP) are indicated when contact precautions do not otherwise apply, for residents with wounds and/or indwelling medical devices regardless of MDRO (multi drug resistant organisms) colonization. |