STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045433	A. Building B. Wing	08/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Corning Therapy and Living Center	831 North Missouri Corning, AR 72422

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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. 50682 Based on observation, interviews, and record review, it was determined the facility failed to ensure interventions that were implemented in the care plan to promote safety while smoking for one (Resident #17) of one sampled resident. Findings include: Review of facility policy titled Smoking Policy-Residents dated 2001 (revised July 2017) indicated This facility shall establish and maintain safe resident smoking practices. A review of an Admission Record indicated the facility admitted Resident # 17 on 2/01/2024 with diagnoses that included Nontraumatic Ischemic Infarction of Muscle of left lower leg, persistent Atrial Fibrillation and behavioral disturbance. The annual Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 2/08/2024, revealed Resident #17 had a Brief Interview for Mental Status (BIMS) score of 11, which indicated the resident was moderately impaired for their daily decision making. Review of Resident #17's Care Plan revised 2/19/2024 revealed the resident is a smoker and requires supervision while smoking. Interventions included The resident requires a smoking apron while smoking. Date Initiated: 02/19/2024. On 8/07/2024 at 11:30 AM, Resident #17 was observed smoking and Resident #17 did not have a smoking apron on. During an interview with Certified Nursing Assistant (CNA) #1 at 11:35 AM, was asked if Resident #17 should have on a smoking apron. CNA#1 said the resident should have a smoking apron on to protect himself if he should drop the cigarette. Medication Administration Tech #3 was asked on 8/07/2024 at 11:35 AM to observe Resident #17 while smoking. She was asked if Resident #17 had a smoking apron on and if they should have on one. She stated Resident #17 did not have an apron on but, they should. (continued on next page)

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

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/07/2024 at 11:40 AM, Licensed Practical Nurse (LPN) #2 was asked if Resident #17 should wear a smoking apron while smoking. She stated all smokers should wear a smoking apron to prevent an accident while smoking. During an interview on 8/07/2024 at 1:00 PM, Nurse Consultant stated the resident should have been wearing a smoking apron to prevent any accidents while smoking.

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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 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide activities to meet all resident's needs. 49689 Based on observations, record review, interviews, and facility policy review, the facility failed to ensure that activities were provided for all 42 residents that reside in the building. The findings included: On 8/5/24 at 2:33 PM, the Surveyor did not observe activities upon entry of the secure unit. On 8/6/24 at 8:57 AM, the Surveyor observed no activities occurring on the secure unit. On 8/6/24 at 10:08 AM, the Surveyor observed staff offering the residents a snack. No activities observed this morning on the secured unit. On 8/6/24 at 2:01 PM, the Surveyor observed no activities on the secure unit. On 8/7/24 at 8:52 AM, the Surveyor observed no activities on the secure unit. One Certified Nursing Assistant (CNA) observed sitting at desk in day room with residents that were watching television. On 8/7/24 at 9:46 AM, the Surveyor observed no activities being provided on the secure unit. One CNA observed sitting at desk in day room with residents that are watching television. On 8/7/24 at 10:04 AM, the Surveyor observed staff offering snacks to the residents. No activities observed this morning on the secure unit. On 8/7/24 at 11:14 AM, the Surveyor observed no activities being provided on the secure unit. One CNA observed sitting at desk in day room with residents that are watching television. On 8/7/24 at 12:04 PM, the Surveyor observed no activities being provided on the secure unit. On 8/7/24 at 1:15 PM, the Surveyor observed no activities being provided on the secured unit. One CNA observed sitting at desk in day room with residents that are watching television. On 8/7/24 at 2:02 PM, the Surveyor observed no activities being provided on the secured unit. One CNA observed sitting at desk in day room with residents that are watching television. During an interview on 8/7/24 at 1:53 PM, Resident #28's family member stated activities are not performed on the secure unit. During an interview on 8/7/24 at 2:42 PM, the Activities Director stated activities should be performed on the secure unit daily. She confirmed activities had not been performed daily for the past 30 days During an interview on 8/7/24 at 3:09 PM, CNA #4 stated activities should be performed every day on the secure unit. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 8/8/2024 at 9:19 AM, the Administrator stated activities should be offered every day for those residents that were willing to participate, that activities provided daily were a resident's right, and each activity should be documented in the resident's electronic health record when they occur. The Administrator stated the benefits of activities included socialization, decreased depression, and an overall better quality of life. The Administrator stated lack of activities could lead to depression and a decline in the residents' health. The Administrator stated the Social Service Activity Director was in charge of the activities for the facility, except the secured unit, which was completed by a neighborhood coordinator/CNA who also provided direct care to the residents on the secured unit. The facility provided a policy titled, Activity Program with a revision date of June 2018 revealed activity programs are designed to meet the needs and interests of and support the physical, mental, and psychosocial well-being of each resident. Policy Interpretation and Implementation noted the activities program is ongoing and is to enhance the resident's sense of well-being and to promote or enhance physical, cognitive or emotional health. Activities are scheduled seven days a week. Resident activity participation is to be documented in the resident's medical record.

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43262 50682 Based on record review, document review, observations, interviews, and facility policy review, the facility failed to ensure adequate supervision was provided to prevent an elopement, as evidenced by failure to ensure increased supervision was provided during periods of increased exit-seeking behaviors for 1 (Resident # 240) sampled resident. The failed practice resulted in past noncompliance at the level of immediate jeopardy (IJ), which caused, or could have caused serious harm, injury or death to Resident # 240 who was at high risk for elopement. Resident # 240 eloped from the facility and was found approximately 300 feet from the facility on 7/30/2023 at 5:45 PM after the facility received a call from a passerby stating they drove by facility and saw elderly [gender of Resident] sitting by the road. A visitor leaving the facility pulled their vehicle between the resident and the highway and remained with the resident until staff reached the resident. The Administrator and Nurse Consultant were notified of the past immediate jeopardy on 8/08/2024 at 1:12 PM. The findings are: A review of a Medical Diagnosis Record indicated the facility admitted Resident # 240 with a medical diagnosis (dx) of Dementia, with agitation. The admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 06/05/2023 revealed Resident # 240 scored 06 (0-7 indicates severe cognitive impairment) on a Brief Interview for Mental Status (BIMS), exhibited wandering behavior in section E0900, and in section E1100 change of behavior or other symptoms was revealed current behavior or wandering was worse compared to prior assessment. Review of Resident # 240's Care Plan, initiated 11/05/2020, revealed the resident was an elopement risk/wanderer r/t (related to) Dementia. Resident # 240 was disoriented to place, had impaired safety awareness and a history of attempts to leave facility unattended. Resident wandered aimlessly and interventions included distract resident from wandering by offering diversions, structured activities, food, conversation, television or books. The care plan did not address Resident # 240's preferences. A review of a nursing Progress Note Type: Alert Note dated 7/24/2023 at 8:11 AM revealed Resident # 240 was wandering and unable to redirect. A review of a nursing Progress Note Type: Hot Rack Charting dated 7/24/2023 at 7:05 PM revealed Resident # 240 had increased anxiety that medication had minimal effect, that resident was exit seeking and wandered around the facility yelling Grandpa let us out and was unable to be reoriented or redirected. A review of a nursing Progress Note Type: Hot Rack Charting dated 7/25/2023 at 4:15 PM revealed Resident # 240 wandered around the facility and into other resident rooms having to be redirected. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A review of a nursing Progress Note Type: General Note dated 7/28/2023 at 7:13 PM revealed Resident # 240 rolled up and down corridor in wheelchair stating, God, please help us! and disturbing other residents and was unable to be redirected. A review of a nursing Progress Note Type: Hot Rack Charting dated 7/29/2023 at 6:49 PM revealed Resident # 240 had been up and about the facility wandering to each exit stating let me out requiring frequent supervision from staff required for safety. The Resident was observed to become easily agitated with staff at times and was redirected. The past noncompliance began on 7/30/2023 at 5:45 PM, when the facility received a call from a passerby who stated, Hey I just drove by your facility and saw elderly [gender of resident] sitting by the road and wanted to let you know! Resident # 240 was observed sitting by the highway in a wheelchair (w/c). A visitor leaving the facility pulled their vehicle between the resident and the highway and remained with the resident until staff reached the resident. Resident # 240 was returned to the facility and placed on the secured unit. The Resident's family member and on-call physician were notified. A review of a nursing Progress Note Type: Nursing I & A (incident & accident) dated 7/30/2023 at 7:25 PM written by Registered Nurse (RN) # 8 indicated a call to the Nurse Practitioner at 7:58 PM and family contact at 7:55 PM revealed that Resident # 240 exited the facility via the front door and was at the end of the driveway. Immediate intervention upon Resident return to the facility was Resident # 240 was placed on the secured unit for safety due to exit seeking and wandering. A review of a nursing Progress Note Type: Nursing I & A follow up dated 07/30/2023 at 8:25 PM written by the Director of Nurses (DON) indicated the facility received a call from a passerby who stated, Hey I just drove by your facility and saw elderly [gender] sitting by the road and wanted to let you know! Resident # 240 was observed sitting by the highway in a wheelchair (w/c). A visitor leaving the facility pulled their vehicle between the resident and the highway and remained with the resident until staff came. Resident # 240 was returned to the facility and placed on the secured unit. Resident # 240's family member and the on-call physician notified with orders received and processed. The Long-Term Intervention: Resident placed on secure dementia unit and intervention was added to the care plan. Review of Resident # 240's Care Plan initiated 11/22/2023 revealed resident needed secured/special care neighborhood due to behaviors, wondering and exit seeking. Interventions included walking with or redirecting resident, to engage in diversionary activity such as towel folding, music, or coloring and to have supplies and activity resources readily available and scheduled in the neighborhood. During an interview on 8/07/2024 at 4:45 PM, Certified Nurses Aid (CNA) # 5 said it happened during a night shift that she wasn't working. She was told someone called the facility, and the staff didn't know for sure how resident got out or how long resident was outside, but they thought [gender] followed someone outside. CNA # 5 said Resident # 240 had a history of wandering around the facility and going in/out of other resident's rooms, going to the doors and looking out. The CNA said she did not remember having an in-service or training related to (r/t) elopement afterwards. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 8/07/2024 at 4:55 PM, CNA # 6 said, she was told about the elopement the next morning during report, that Resident # 240 got out without staff knowing and was only discovered after someone called the facility to report it. She didn't know if Resident # 240 was wandering that night but had previously seen resident wandering and exit seeking. As far as she could remember, they did not a training related to elopement after the incident. During a telephone interview on 8/07/2024 at 5:40 PM, CNA # 7 said that she didn't know the exact time, maybe between 5:00 PM and 6:00 PM, but remembered Resident # 240 was seated in w/c out in the front foyer. CNA # 7 said that staff didn't know the resident was gone until the facility received a phone call from someone driving down the road saying that there was someone in a w/c out by the road. None of the staff working that night knew how the resident got out but assumed that Resident # 240 went out the front door when a visitor left. CNA # 7 said Registered Nurse (RN) # 8 and CNA # 5 went outside to get the resident. Resident # 240 was crying, screaming and yelling at RN # 8 while the RN was trying to assess resident for heat related injury because it was hot outside. CNA # 7 recalled seeing Resident # 240 wandering around the facility, going to the entrance and exit doors and looking outside, but did not observe resident wandering or at the door that evening, but remembered resident seated in the front foyer. CNA # 7 said she couldn't remember if an in-service was done after the elopement or in the last year. During a telephone interview on 8/08/2024 at 8:55 AM, the DON said she was called by RN # 8 and was told about Resident # 240 leaving the building. She came to the facility to follow protocol and fill out an I&A note. She was told that Resident # 240 must have left through the front door with a visitor and was found on the side of the highway by a passerby who called the facility. RN # 8 assessed the resident for possible heat stroke or other injuries. The DON said she thought it was warm that day since it was in July. The DON said that RN # 8 called the resident's family member, herself, the APN (Advanced Practice Nurse) and [name] the Administrator, who would have a done a reportable and call the police. She said she couldn't remember if an in-service on elopement was done but she was pretty sure the facility did. During an interview on 8/08/2024 at 10:44 AM, the Administrator said the facility did not have cameras but the best they could tell, a visitor went out the front door and Resident # 240 went out with the visitor. An internal investigation was conducted with the Action Plan completion date of 7/30/2023 on the same day resident eloped. The Action Plan included: An elopement assessment upon admission, quarterly and PRN, residents identified as high risk for elopement care planned with appropriate interventions, resident that demonstrate new exit seeking/elopement behaviors have an updated assessment. Elopement Drill conducted 7/31/23 at 3:15 PM, Elopement Drill conducted 8/9/23 at 4:35 PM, Elopement Drill conducted 10/03/23 at 11:20 AM, Weekly Exit Door Inspections for the months of August 2023, September 2023, October 2023, November 2023, December 2023, January 2024, February 2024, March 2024, April 2024, May 2024, June 2024, July 2024 and the first week of August 2024. The Administrator said, I did not report to the OLTC (Office of Long-Term Care) because Resident # 240 did not leave the premises, so it was not considered an elopement and necessary to report. Review of facility policy titled Elopements with a revision date of December 2007 indicated Staff shall investigate and report all cases of missing residents to the administrator. Elopement is a resident missing from the facility without staff knowledge. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 8/08/2024 at 11:30 AM an elopement in-service completed on 7/30/2023 with fifty-two staff signatures was provided by the Administrator. Out of fifty-two, twenty-seven were still employed at the facility. At 11:35 AM Licensed Practical Nurse (LPN) # 2 said I can't remember an elopement in-service or an elopement drill. At 11:42 AM CNA # 9 said I can't honestly say if there had been an elopement in-service or drill. At 11:48 AM Housekeeping # 10 said I remember an elopement drill and I'm pretty sure there was an in-service sometime last year. At 11:49 AM Maintenance said we had elopement drills, in-services and an action plan to prevent further incidents. During an observation an In-service education notebook at the nurse's station on 8/08/2024 at 12:07 PM did not have copies of an Elopement in-service inside it. At 12:10 PM LPN # 11 returned a phone call after a message was left from surveyor. LPN said, I don't remember signing an in-service on elopement or having a drill. During a telephone interview on 08/08/2024 at 12:20 PM, RN # 8 said she remembered the night of the elopement. She assumed Resident # 240 went out the front door with a visitor, but she didn't think the visitor realized it was a resident trying to leave. RN # 8 said the resident used a wheelchair and was 1 person transfer assist but could get around good in the chair. Resident # 240 was found outside close to the road and was quickly assessed outside, then a full assessment done upon entry. RN # 8 said the resident was monitored for behaviors and had a history of wandering. She couldn't remember having an elopement in service in the last 6 months but was pretty sure the facility had one after the elopement. On 8/08/2024 at 12:52 PM, guidance from the State office indicated to provide facility with Immediate Jeopardy (IJ)Template. At 1:12 PM, Immediate Jeopardy (IJ) template was signed by Administrator and Nurse Consultant.