

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045439	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/19/2024
NAME OF PROVIDER OR SUPPLIER Gosnell Health and Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE 700 Moody Street Gosnell, AR 72315	

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)
<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives an accurate assessment.</p> <p>49689</p> <p>Based on observation, record review, and interview the facility failed to accurately code a Minimum Data Set (MDS) for a contracture under Section GG for one out of one sampled residents (Resident #3).</p> <p>These are the findings:</p> <p>A review of the Order Summary revealed Resident #3 had a diagnosis of stroke with left sided weakness/paralysis.</p> <p>A review of the quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 06/05/2024 reveals that Resident #3 scored a 12 (moderate cognitive impairment) on the Brief Interview for Mental Status (BIMS). A review of Section GG in the MDS reveals that for upper limited mobility was marked no impairment.</p> <p>On 09/16/2024 at 11:36 AM, the surveyor observed Resident #3 in bed with left hand contracture with no intervention in place. Surveyor observed that Resident #3 could not stretch the hand out, and they stated, that they have had the contracture for a while.</p> <p>On 09/16/2024 at 3:00 PM Surveyor observed Resident #3 up in wheelchair with left hand contracture and no interventions.</p> <p>On 09/19/2024 at 9:25 AM, during an interview Certified Nursing Assistant #4 (CNA) stated that resident has had a contracture since admission, and they were not aware of any interventions for contracture.</p> <p>On 09/19/2024 at 9:45 AM, during an interview Licensed Practical Nurse (LPN) #5 stated that Resident #3 has had a contracture since admission and I believe we do range of motion for the contracture.</p> <p>On 09/19/2024 at 9:29 AM, during an interview the MDS Coordinator confirmed that limited mobility is not marked on Section GG for Resident #3's contracture. The MDS Coordinator stated an accurate assessment is important because that is what care is being provided to the resident and gives an accurate description of the resident. MDS Coordinator continued Resident #3 without an accurate assessment does not help capture what is needed for interventions to prevent it from worsening.</p> <p>(continued on next page)</p>

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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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 09/19/2024 at 10:15 AM, during an interview the Director of Nursing (DON) stated that an accurate assessment populates the care plan with interventions for how we take care of the resident. The DON then stated that for a contracture an accurate assessment is needed to maintain and treat the contracture, and to be able to add interventions in the care plan.</p> <p>On 09/19/2024 at 10:25 AM, the MDS Consultant stated that the facility follows the RAI Manual for MDS and there are no separate policies.</p>

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<p>F 0687</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate foot care.</p> <p>49689</p> <p>Based on observation, record review, and interview, the facility failed to ensure residents who required assistance with foot care were regularly provided with the necessary assistance to maintain good hygiene and grooming, as evidenced by failure to ensure toenails were kept clean and trimmed for one resident of one sampled resident. (Resident #24).</p> <p>These are the findings:</p> <p>Review of an Order Summary Report revealed that Resident #24 had diagnoses of dementia, diabetes, chronic kidney disease, congestive heart failure, and need for assistance with personal care. There was no order for diabetic nail care for the nursing staff.</p> <p>Review of a Significant Change Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 08/23/2024 revealed that Resident #24 scored a 4 (severe cognitive impairment) on the Brief Interview for Mental Status (BIMS).</p> <p>Review of a Care Plan initiated on 03/26/2024 revealed that Resident #24 had an activity of daily living (ADL) deficit that stated to check nail length, trim, and clean on bath day and as necessary. Report any changes to the nurse.</p> <p>On 09/16/2024 at 11:16 AM, Surveyor observed Resident #24 sitting in a recliner with uncovered feet propped up, toenails were long, jagged, and thick, the right greater toenail was jagged and missing the middle part of the toenail. Resident #24 stated my toenails are long and that one missing part of the toenail is worrying me; I would like to have them trimmed.</p> <p>On 09/17/2024 at 9:30 AM, Surveyor observed that toenail care had not been done.</p> <p>On 09/18/2024 at 3:00 PM, Surveyor observed that toenail care had not been done.</p> <p>On 09/18/2024 at 4:00 PM, during an interview Certified Nursing Assistant #3 (CNA) stated that the nails had not been reported as Hospice usually gives Resident #24 a bath. CNA #3 then stated Resident #24 usually does not need much help either. CNA #3 then described the nails as long, thick, jagged especially that one big toe and that they needed trimmed. CNA #3 stated the nurse does nail care as the resident is diabetic, otherwise a CNA does it as needed. CNA #3 then stated the toenails in the current condition could set up an infection or sores as they could snag on the resident's shoes or socks ripping the nail.</p> <p>On 09/18/2024 at 4:14 PM, during an interview Licensed Practical Nurse #5 (LPN #5) stated Resident #24's toenails had not been reported to them, and that they look terrible and need to be taken care of. LPN #5 then stated the resident was a diabetic and nail care was important as they can be ripped off by snagging on shoes, socks or blankets. LPN #5 continued it could set up sore or infection. LPN #5 confirmed they did not have a current order for diabetic nail care for Resident #24.</p> <p>(continued on next page)</p>		

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<p>F 0687</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 09/19/2024 at 10:15 AM, during an interview the Director of Nursing (DON) stated that having orders for diabetic nail care was important so the staff could actually perform and chart on nail care. The DON then stated nailcare was for skin protection, not cutting themselves, and overall health for diabetics to not cause sores or infection.</p> <p>Review of a facility policy Fingernails/Toenails, Care of revealed, General Guidelines</p> <ol style="list-style-type: none"> 1 . Nail care includes daily cleaning and regular trimming. 2. Proper nail care can aid in the prevention of skin problems around the nail bed. 3. Unless otherwise permitted, do not trim the nails of diabetic residents or residents with circulatory impairments. 4. Trimmed and smooth nails prevent the resident from accidentally scratching and injuring his or her skin. 5. Watch for and report any changes in the color of the skin around the nail bed. blueness of the nails, any signs of poor circulation, cracking of the skin between the toes, any swelling, bleeding, etc. 6. Stop and report to the nurse supervisor if there is evidence of ingrown nails, infections, pain, or if nails are too hard or too thick to cut with ease. 		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>50923</p> <p>Based on interviews, record review, observations, and document review, the facility failed to prevent an accident that caused serious injury during a van with lift transfer due to not following the manufacturer's guidelines for the lift and training for 1 (Resident #199) of 1 resident reviewed for accidents. This deficient practice resulted in Resident #199 sustaining a left ankle fracture on 09/10/2024, and a suspected fracture to the sacrum.</p> <p>The findings are:</p> <p>On 09/17/24 at 11:09 AM, during an interview with [NAME] President of Operations regarding incident he confirmed Certified Nurse Aide #1 (CNA #1) assisted with unloading Resident #199. CNA #1 failed to confirm the lift gate was up and ready for the transfer which caused the fall. CNA #1 was suspended until the end of the facility investigation, then terminated.</p> <p>On 09/17/24 at 11:11 AM, Director of Nursing (DON) interviewed regarding the incident on 09/10/2024 involving Resident #199. When asked what her immediate action was following the incident, she confirmed she assessed Resident #199 then sent the resident to the nearest emergency department for an evaluation and treatment. She confirmed provider and family were notified.</p> <p>On 09/17/24 at 11:31 AM, Resident #199 was interviewed regarding incident. Resident stated, I was just sitting there in the van waiting to be taken back in and all of a sudden I was falling backwards. It happened very quick. My body was all catawampus, and was like a V, my legs came up to my body. Resident confirmed pain level was controlled with current treatment.</p> <p>On 09/17/24 at 02:04 PM, Maintenance Director was interviewed regarding mechanical actions/demonstration of lift on the 2018 van. Staff demonstrated the process of loading and unloading residents in wheelchairs. He demonstrated the warning threshold plate working properly (safety mechanism to warn the gate is not up).</p> <p>During an interview on 09/17/24 at 2:30 PM, CNA #7 stated she returned from assisting the first resident into the building and came back to assist CNA #1 with the last resident (Resident #199). The lift gate was down from the first transfer, and stated as she approached the van, she saw Resident #199 fall from the van in the wheelchair, and then CNA #1 fell out of the van soon after. CNA #7 confirmed she completed re-training on about 09/12/2024.</p> <p>On 09/17/24 at 2:40 PM, the Maintenance Director was interviewed regarding the van transport wheelchair training 01/16/2024. He confirmed CNA #1 was present for the class. Maintenance Director confirmed he attended the re-training for van transfers on 09/12/2024.</p> <p>On 09/17/24 at 02:44 PM, the Administrator was interviewed regarding the incident involving Resident #199. The Administrator confirmed CNA #1 did not follow the manufacturer's guidelines or the training, which CNA #1 last completed on January 16, 2024.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>On 09/17/24 at 03:27 PM, CNA #1 was interviewed regarding the incident on 9/10/2024. She stated, I assisted [CNA #7] in undoing the floor strap for the other resident. CNA #7 took the other resident inside the building, and I was in the process of undoing the floor strap for Resident #199 and preparing to transfer the resident. I said okay, and then I heard CNA #7 say okay, so I thought that meant she was ready and the lift was up, so I proceeded to push the resident to the edge, then both of us fell and that's when I knew the gate was not up. When asked if she looked to see if the gate was lifted, she stated, I am too short to see over the resident in the wheelchair. When asked about safety mechanism to alert gate is not up, CNA #1 stated, Are you talking about the beeping? It always beeps regardless of if it's up or down. CNA #1 stated, My last transfer training was at least two years ago. When asked if CNA #1 had worked as a transporter before her other roles, she stated, Yes, I used to be a transporter, then I switched to HR [Human Resources] about 6 years ago, but I was filling in doing transports.</p> <p>On 09/17/24 at 12:17 PM, the surveyor reviewed video footage of the incident that happened on 09/10/2024 at approximately 12:30 PM. The video shows the return of the transport van with two residents, CNA #1 and CNA #7. One resident was unloaded from the transport van without incident by CNA #7 and taken inside the facility. The gate remained lowered. CNA #1 was seen holding the wheelchair, facing the resident, both are located at the rear exit. As CNA #7 walked out of the front door, she walked toward the back of the van and noticed CNA #1 was struggling to hold the wheelchair/resident inside the back of the van. CNA #7 approached the van to assist but was unable to prevent the resident from falling out of the van. Resident #199 fell approximately 24 (measured from floor of van to base of the lift lowered). Resident #199's legs spread outward in opposite directions. The resident remained seated inside the wheelchair. CNA #1 also fell out of the back of the van, and partially landed on the left portion of the wheelchair, struck Resident #199's left leg/foot, pressing the resident's foot against the left foot pedal of the wheelchair. This action potentially caused the fracture to the left ankle. Resident #199 also sustained a suspected fracture to the sacrum (low back area).</p> <p>Reviewed the undated, Operator's Manual for the facility's wheelchair lift. Under the section labeled operation notes, vehicle loading and unloading, it read, The platform must be fully raised (at floor level) and the inner roll stop (bridge plate) must be properly positioned when loading or unloading passengers in or out of vehicle. It is the responsibility of the lift attendant to ensure the platform, and the inner roll stop are properly positioned at floor level when loading and unloading passengers.</p> <p>Review of training provided to CNA #1 on van transfers including the most recent dated 01/16/2024. The training acknowledgement was signed, and the signature matches other signatures in CNA #1 employment file. Other attendees of the van transfer training on 01/16/2024 confirmed CNA #1 was present for that training.</p> <p>A requirement for training included each of the transport staff to demonstrate proper loading and unloading techniques with a focus on understanding all safety measures. Transport staff were required to demonstrate proper operation of the transport van equipment to the instructor.</p> <p>Reviewed facility undated policy titled Accidents and Incidents - Investigating and Reporting Policy and the Facility Van/Vehicle Usage, undated policy which was consistent with the facility's actions following the incident on 09/10/2024. The facility completed an in-service for all staff on Abuse/Neglect dated 09/10/2024.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>On 09/18/24 at 10:49 AM, interviewed [named] Van and Mobility Mechanic that inspected the transport vans following the incident. He confirmed the safety mechanism on the threshold warning plate would not beep when the gate is fully up and engaged. [Named] Van and Mobility Mechanic also confirmed no repairs were needed on the lift or any other portion of the vans at time of inspection (09/16/2024).</p> <p>During an interview on 09/19/24 at 11:10 AM, CNA #6 confirmed the last training regarding van transport was on 09/13/2024, and attendees were required to demonstrate the skills of loading and unloading residents from the transport van via wheelchair, and safety measures.</p> <p>The facility implemented corrective actions which were completed prior to the State Agency's completion of its survey; thus, it was determined to be a Past Noncompliance citation.</p> <p>The facility has implemented the following plan of correction to correct the deficient practice effective 09/11/2024.</p> <p>Facility Plan of Correction:</p> <p>Step #1 Corrective Plan:</p> <p>On 9/10/2024 upon notification of deficient practice, the Administrator/designee immediately disabled the transport van from this incident from all further transports until investigation and review was completed.</p> <p>The transportation aide was not permitted to perform any further transports or transfers until corrective measures were completed and she was suspended from employment pending investigation process.</p> <p>Step #2 Identification of others with the potential of being affected:</p> <p>On 9/10/2024 the DON/Designee determined, through medical record review and transportation data for the last two weeks, that five residents had to potential to be affected and assessed all residents identified to ensure no injuries related to transportation had occurred.</p> <p>Step #3 To ensure deficient practice does not reoccur:</p> <p>On 9/10/2024, the Administrator made alternate arrangements for all resident transports until completion of transportation aide in-services with return demonstration could be completed. The maintenance director assisted in ensuring this staff education was completed.</p> <p>Both facility vans were placed in no transport mode until a thorough van/equipment inspection could be completed.</p> <p>Step #4 Monitoring:</p> <p>Administrator/designee will monitor loading and unloading of residents to facility vans for transport 3 times a week times 4 weeks minimally or until compliance is achieved. Findings will be documented on a monitoring log.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>The facility implemented a plan for retraining all transport staff which was completed on several different dates, but the final transport staff member completed the training on 09/13/2024. The staff watched the manufacturer training video linked below:</p> <p>https://youtube.com/watch?v=vDLdUXcotEc&si=LgpoAUyOrtwuHRJV</p> <p>The transport staff completed training along with demonstration of the skills of loading and unloading a resident in a wheelchair. Training also included safety measures for safe transportation of residents. This training will be ongoing.</p>		