STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045466	A. Building B. Wing	10/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Green House Cottages of Poplar Grove	7801 Kanis Rd Little Rock, AR 72204

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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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47916 Based on observation, record review, and interview, it was determined that the facility failed to ensure that a comprehensive care plan addressed pain for 1 of 1 sampled resident (Resident #58) reviewed for pain management to ensure appropriate interventions were in place. The Findings include: Review of Resident #58's Care Plan revealed diagnoses of cancer, inability to use legs, and type II diabetes. Review of an Admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 09/06/2024 suggest a Brief Interview for Mental Status (BIMS) score of 15 (13-15 indicates cognitively intact) Section J0100 a. suggested resident was on scheduled pain medication, section J0200 showed pain assessment interview should be conducted, J0300 indicated pain was present, J0410 indicated Resident #58 had occasional pain, and section J0510 on the MDS suggested pain occasionally affects Resident #58's sleep. A review of Physician Orders, dated 09/05/2024, revealed that pain should be evaluated every shift, and a scheduled pain medication should be given every 8 hours. A review of Physician Orders, dated 09/17/2024, revealed an opioid pain medication was scheduled 1 tablet every 6 hours as needed for pain. A review of Physician Orders, dated 09/25/2024, revealed an opioid pain patch should be applied every three days at bedtime for pain. During an interview with Shahbaz #8 on 10/03/24 at 11:46 PM, Shahbaz #8 revealed Resident #58 had spinal cancer and frequently complained of back pain. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/03/24 at 3:25 PM, MDS Nurse #2 confirmed the MDS dated [DATE] showed Resident #58 received scheduled pain medication and confirmed the Shahbaz would look in the care plan to find interventions. MDS Nurse #2 looked in the computer records and stated she was not seeing pain on Resident #58's care plan but pain should be, and MDS Nurse #2 or the other MDS Nurse #3 were responsible for addressing pain on the care plan because the MDS looks at the resident as a whole and it is important that things make it from the MDS to the care plan to ensure residents get the care they need. MDS Nurse #2 confirmed that the Resident Assessment Instrument (RAI) manual is used as a guide for the MDS. The Surveyor asked MDS Nurse #2 to provide documentation from the RAI manual showing where the process was missed with care planning. On 10/03/24 at 3:45 PM, MDS Nurse #2 reported, she could not find anything in the RAI manual, but by documenting yes on Care Area Assessment (CAA) Worksheet it should carry over to the care plan

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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. 47916 49596 Based on observation, record review, interview, and facility policy review, it was determined that the facility failed to ensure the rear casters of the mechanical lift were not locked with lifting and lowering resident to prevent accidents and injuries affecting 1 sampled (Resident #270) of 4 sampled residents reviewed for accidents. The facility failed to ensure the residents environment was free of accidents and hazards for 1 sampled (Resident #48) of 4 sampled residents reviewed for accidents and hazards. The Findings include: Review of Resident #270's Care Plan revealed diagnoses of subdural hemorrhage, respiratory failure, and type II diabetes. The Admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 09/21/2024 indicated a Brief Interview for Mental Status (BIMS) score of 13 (13-15 indicates cognitively intact). Resident#270 required total assistance for toileting, bathing, and dressing the lower body. Review of Resident #270's Care Plan, dated 09/19/2024, revealed resident was dependent on helpers, was unable to provide any effort for toileting and required the assistance of 2 helpers. Review of an in-service titled Mechanical Lift Usage Instructions and Training for All Staff, dated 07/12/24, revealed the mechanical lift was for safe movement of residents. The in-service did not address use of the rear casters/wheels while raising or lowering a resident. On 10/01/24 at 9:25 AM, Shahbaz #4 was observed rolling a mechanical lift under Resident #270's bed with the legs in the open position, rear casters were locked, and Resident #270 was raised up from the bed. A wheelchair was rolled between the open legs, rear casters/wheels were locked, and Resident #270 was lowered into a wheelchair. During an interview with Shahbaz #4 on 10/01/24 at 09:39 AM, Shahbaz #4 stated they locked the rear wheels when lifting and lowering Resident #270 with the mechanical lift so the lift did not roll away, because it could injure the resident. Shabaz #5 said the wheels are locked so it does not move while lifting and lowering residents to prevent tipping. On 10/02/24 at 08:53 AM, Director of Nursing (DON) was asked the process for lifting and lowering a resident with a lift. DON stated, the legs of the mechanical lift should be open, and the rear wheels should be locked so that it cannot move and cause an injury to the resident. The Surveyor requested a copy of mechanical lift in-services, and the mechanical lift user guide. On 10/02/24 at 09:41 AM, The Administrator provided the portable lift owner's manual and page 31 revealed, when lifting and moving a resident, the rear casters/wheels of the mechanical lift should not be locked to avoid the resident and lift from tipping and endangering the resident. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/01/24 at 8:53 AM, surveyor observed an unsecured oxygen tank sitting inside a black bag in the bathroom propped up on the vanity. On 10/01/24 at 1:41 PM, surveyor observed an unsecured oxygen tank sitting inside a black bag in the bathroom propped up on the vanity. On 10/02/24 at 8:58 AM, surveyor observed an unsecured oxygen tank sitting inside a black bag in bathroom propped up on the vanity. On 10/02/24 at 8:59 AM, Resident #48 stated they does not use oxygen and had asked staff to take the oxygen tank out of their bathroom several times, but the staff had not taken it out and it needed to go in the room for oxygen tanks. On 10/02/24 at 9:01 AM, Licensed Practical Nurse (LPN) #1, informed the surveyor the tank should not be in the bathroom, and it should be in the oxygen room. LPN #1 said her concern was if the tank fell over it could blow up. On 10/02/24 at 9:08 AM, a review of Resident #48's Physician Orders reflected Resident #48 did not have an order for oxygen. Resident #48 was not care planned for oxygen and Resident #48's MDS does not indicate they used oxygen. On 10/04/24 at 8:33 AM, the Director of Nursing (DON) provided the policy Handling of Oxygen and Flammable Gas which states oxygen cylinders will be stored in a designated ventilated area, stored in a safe manner to prevent cylinder from fall over. On 10/04/24 at 8:28 AM, the Assistant Director of Nursing (ADON)/Infection Preventionist (IP) stated the oxygen cylinders should be stored in the supply closet in the canister holder, and they cannot be on the floor due to safety. The oxygen cylinders could fall over and cause a combustion. On 10/04/24 at 8:34 AM, the DON stated oxygen cylinders should be stored in the supply closet in cylinder holders because they could fall over and cause a flammable hazard, and they should not be stored in a bathroom.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. 51381 Based on observation, record review, and interview the facility failed to ensure oxygen was administered at the flow rate ordered by the physician to reduce the potential for respiratory complications for 1 (Resident #2) of 2 sampled residents that were reviewed for respiratory therapy. The findings are: Review of a Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 6/27/24 indicated Resident #2 had diagnoses of chronic obstructive pulmonary disease, stroke, dementia and functional quadriplegia (loss of movement in all four limbs), scored 3 (0-7 indicates severe impairment) on the Brief Interview for Mental Status (BIMS) and received oxygen therapy. A Review of a Physician's order, dated 06/14/2022 indicated, May have Oxygen 2-3 LPM [liters per minute] Via N/C [Nasal Cannula] as needed every shift for Shortness of breath and/or pulse ox [oximetry] [oxygen level] < [less than] 90%. Review of a Care Plan with a revision date of 01/18/2024 indicated Resident #2 received oxygen therapy at 2 liters per nasal cannula as needed with the goal being the resident would have no signs or symptoms of poor oxygen absorption. A task/intervention included staff to observe the oxygen flow rate matched the ordered amount when oxygen was in use. On 9/30/2024 at 12:31 PM, Resident #2 was observed lying in bed, with O2 at 1.5 liters/minute via NC. On 10/01/2024 at 11:00 AM, Resident #2 was observed lying in bed with O2 at 1.5 liters/minute via NC. On 10/01/2024 at 5:45 PM, Resident #2 was observed lying in bed with O2 at 1.5 liters/minute per NC. On 10/02/2024 at 2:24 PM, the surveyor asked Licensed Practical Nurse (LPN) #1 to accompany the surveyor to Resident #2's room to observe oxygen therapy administration. Upon interview LPN #1 stated that the oxygen flow rate was 1.5 liter/minute and should be at 2L for resident #2. LPN #1 adjusted the flowmeter to 2 Liters per minute at that time. LPN #1 stated the process for ensuring flow rates of oxygen are correct is up to the LPN to check the provider orders. LPN #1 stated that the flow rate should had been checked earlier that day. LPN #1 stated Resident #2 was able to pull the nasal cannula off at times but was not able to get out of bed and adjust the oxygen rate. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/2/24 at 5:50 PM, an interview of LPN #1 was conducted. LPN #1 stated that provider orders are checked every shift by the LPN. LPN#1 stated the rate could have been accidentally turned down to 1.5 liters/minute when the tubing was being changed on 9/29/2024 but should be at 2 liters/minute. LPN #1 stated the dating of the tubing change was verified this morning and the rate was verified to be at 2 liters/minute, but it must have been looked at incorrectly. LPN #1 stated they could not speak for any incorrect flow rates on 9/30/24 or 10/1/24 because they did not work that day, nor could they speak for any night shift. In addition, LPN #1 stated verification of rates for medications and therapies is important because the order is written to maximize health/life. On 10/3/2024 at 2:30 PM, the Director of Nurses (DON) was interviewed. The DON stated the process for ensuring orders are accurate depends on the order written: for instance, if it is a daily order, it should be checked every day, if it is a monthly order, it is to be checked once per month. The person responsible for checking orders is the licensed nurse. Continuous oxygen would be checked every shift (day shift and night shift). The DON stated it is important for physician orders to be followed as written because it is a physicians' order. On 10/3/2024 at 3:10 PM, the DON was asked for a policy regarding verifying physician orders on oxygen therapy. On 10/4/2024 at 8:33 AM, the policy titled Handling of Oxygen and Flammable Gas OLTC Reg.321 (undated) provided by the Director of Nurses did not address the verification of Oxygen therapy orders.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 47916 Based on observation, interview, and facility policy review, the facility failed to ensure that pills were properly stored in the acceptable package or bottle to prevent mediation errors in Building 1 and failed to ensure a thermometer and temperatures were being monitored in the narcotic refrigerator in Building 4 to ensure medications were stored at an appropriate temperature. Findings include: On 10/02/24 at 8:46 AM, While checking the medication cart in building #1, two loose, round, tan pills and residue of pills were found inside the top drawer of the cabinet, in the far-right corner. Licensed Practical Nurse, (LPN) #6 stated they looked like a supplement, and she would waste the pills. Surveyor asked if someone had to be notified prior to wasting, or if they had a process, and LPN #6 replied, Yes, I would tell the Director of Nursing (DON). LPN #6 stated that it was not appropriate to store loose pills, and she would expect to find pills in an identifiable bottle to protect residents. On 10/02/24 at 8:50 AM, DON arrived and placed the two intact pills in a plastic bag for further inspection, and disposed of the two-round, tan-colored pills. On 10/02/24 at 8:52 AM, DON stated pills should be stored in the proper container and slot because staff could mistakenly administer medication that was not meant for a patient. She reported that nursing was educated every day on medication storage, and the policy was to store medications in their package or bottle. DON confirmed nursing and med techs are responsible for the medication carts, but ultimately nursing was responsible. On 10/03/24 at 8:10 AM, LPN #1 accompanied the surveyor to the medication storage area in Building #4. When asked the temperature of the refrigerator LPN #1 stated that there was no thermometer. She stated the available Ozempic 2 mg (milligram)/3 ml (milliliter) pen and Lorazepam 29.75 ml bottle should be stored at 36-46 degrees Fahrenheit Surveyor asked if she could confirm the temperature of the refrigerator right now and LPN #1 said, Honestly, no I cannot tell you the temperature because there is not a thermometer in the refrigerator. LPN #1 confirmed it was important to make sure the medications were stored at the right temperature, so it would not break down. On 10/03/24 at 8:20 AM, DON was asked who was responsible for checking the narcotic refrigerator temperatures, and where is that documented. DON stated that nurses are responsible to check the temperature every night, and a temperature log was not kept. DON revealed maintenance defrosted the refrigerator on Saturday and may have forgotten to place the thermometer back in the refrigerator. DON confirmed that medications must be at a certain temperature if required. On 10/03/24 at 8:39 AM, Nurse Consultant #7 provided a policy titled Pharmaceutical Services, which revealed medication storage areas are checked monthly for proper storage, expired medications, and cleanliness. Drugs and biologicals are expected to be labeled and stored in accordance to accepted professional principles, in compartments under proper temperature controls. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/03/24 at 9:10 AM, DON provided an in-service titled Nursing, dated 05/06/2024, which revealed nursing was responsible for making sure medications were stored properly and were not to be taken from its original package or bottle. Medications were not to be stored in carts or cabinets without proper labeling.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49596 47916 Based on observation and facility policy review, the facility failed to ensure expired food items were promptly removed/discarded on or before the expiration or use by date to prevent the growth of bacteria, and to ensure food stored in the freezer were appropriately dated. The findings are: On [DATE] at 9:56 AM, a clear, unsealed, package of hot dogs dated [DATE] was stored in the door of the refrigerator, located in the pantry of Cottage 6. The Dietary Manager (DM) immediately removed the hot dogs and said these are not good and should have been used or removed 7 days after being opened because they can cause someone to get sick. On [DATE] at 10:52 AM, While checking the freezer in Building 1 (Dogwood), 2 frozen apple pies were observed without received dates. DM stated, frozen pies should have a received date so staff can tell when they arrived or need to be thrown out. On [DATE] at 12:31 PM DM provided a policy titled Storage of Food and Beverages Brought by Visitors; it does not cover opened prepackaged meat items. On [DATE] at 2:06 PM, DM provided a policy titled Food and Nutrition Services; it does not cover opened prepackaged meat items.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 47916 Based on observation, record review, interview, and facility policy review, it was determined that the facility failed to ensure proper hand hygiene was performed appropriately with peri care to prevent cross contamination, and the spread of infection. This failed practice affected 1 sampled (Resident #270) resident requiring assistance for incontinence care, with the potential to affect 2 sampled (Resident #58, Resident #270) residents reviewed for bowel and bladder. Findings include: Review of Medical Diagnoses Report revealed Resident #270 had a diagnoses of subdural hemorrhage, respiratory failure, and type II diabetes. Review of an Admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 09/21/2024 indicated a Brief Interview for Mental Status (BIMS) score of 13 (13-15 indicates cognitively intact). Resident #270 required moderate assistance with meals and personal hygiene, and total assistance for toileting, bathing, and dressing the lower body. On 10/01/24 at 09:25 AM, Shahbaz #5 was observed removing Resident #270's wet brief after rolling down the front with the right hand, and then removed wipes without performing hand hygiene. Resident #270 urinated during care on 3 clean wipes held over the perineal area, and then wipes were used to wipe the perineal area in a circular motion multiple times before Shahbaz #5 changed gloves. Shahbaz #4 wiped Resident #270's perineal area including wiping the buttocks then pulling up Resident #270's clean pants and placing a lift pad under Resident #270 without performing hand hygiene. On 10/01/24 at 09:45 AM, Shahbaz #4 confirmed that she assisted in wiping Resident #270's buttocks and stated she did not change gloves or perform hand hygiene during incontinence care, or when dressing resident and placing a lift pad under Resident #270. Shahbaz #5 confirmed that after resident urinated the same wipe was used to wipe off the perineal area, before changing gloves. Shahbaz #4 stated there was a concern for cross contamination by not providing proper hand hygiene. On 10/02/24 at 08:56 AM, During an interview with Director of Nursing (DON), DON stated she expects staff to wipe residents one time in one direction, then use a clean wipe in another area, Hand hygiene should be done prior to going from dirty to clean in the resident's environment to prevent cross contamination and the spread of germs. Surveyor requested in-services, and procedures and policies on peri care. Review of an in-service titled Peri Care, dated 07/10/2024, revealed staff were expected to wear gloves, roll down and remove residents brief, and to change gloves when soiled. All staff were to change their gloves when changing from the front to the back. When state was in the building always use 2 people, one for clean and one for dirty. Staff were expected to swipe with 1 wipe front to back.