PRINTED: 08/10/2015 FORM APPROVED OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION |  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  | (X2) MULTIPLE CONSTRUCTION A. BUILDING |  | (X3) DATE SURVEY<br>COMPLETED |  |
|---|--|---|--|--|-------------------------------|--|
|   |  | 045189  | B. WING _                              |  | C<br>07/27/2015               |  |
|   | ROVIDER OR SUPPLIER S HEALTH AND REHAB   | ILITATION, LLC  |  | STREET ADDRESS, CITY, STATE, ZIP CODE 900 MAGNOLIA RD CAMDEN, AR 71701                                     | 1 0112112010                  |  |
| (X4) ID<br>PREFIX<br>TAG                            | (EACH DEFICIENC  | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG                    | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY) | BE COMPLETION                 |  |
| F 000   | is an official, legal do<br>remain unchanged ex<br>correction, correction<br>space. Any discrepar<br>citation(s) will be repo<br>Office (RO) for referra<br>Inspector General (O<br>information is inadver   | 7 (Statement of Deficiencies) cument. All information must scept for entering the plan of dates, and the signature acy in the original deficiency orted to the Dallas Regional all to the Office of the IG) for possible fraud. If tently changed by the State Survey Agency (SA) | FO                                     | 00   |                               |  |
| F 157<br>SS=K                                       | at F282, F309, F314, Complaint #20362 (A unsubstantiated.  Complaint #20365 (A with deficiencies cited 483.10(b)(11) NOTIF (INJURY/DECLINE/R  A facility must immed consult with the resid known, notify the resi or an interested famil accident involving the injury and has the po- intervention; a signific physical, mental, or p deterioration in health status in either life the | n part) with deficiencies cited<br>F332, F441, and F498.<br>R00018472) was<br>R00018476) substantiated<br>d at F157, F224, and F323.<br>Y OF CHANGES  | F 1                                    | 57   |                               |  |

ABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

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.

|                          |  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   | ` ′                 | PLE CONSTRUCTION  G   | (X3) DATE SURVEY COMPLETED  C 07/27/2015 |                            |
|--------------------------|--|--|---------------------|---|--|----------------------------|
|                          |  | 045189 B. WING   |                     |   |  |                            |
|                          | ROVIDER OR SUPPLIER S HEALTH AND REHAB   |  |                     | STREET ADDRESS, CITY, STATE, ZIP COI<br>900 MAGNOLIA RD<br>CAMDEN, AR 71701               | •  | 1112112015                 |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC  | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CO<br>(EACH CORRECTIVE ACTIO<br>CROSS-REFERENCED TO THI<br>DEFICIENCY) | N SHOULD BE<br>E APPROPRIATE             | (X5)<br>COMPLETION<br>DATE |
| F 157                    | treatment); or a decise the resident from the §483.12(a).  The facility must also and, if known, the resor interested family in change in room or rospecified in §483.15 resident rights under regulations as specifications.  The facility must record the address and photographs. | eed to discontinue an ment due to adverse commence a new form of sion to transfer or discharge facility as specified in promptly notify the resident sident's legal representative nember when there is a ommate assignment as   | F1                  |   |  |                            |
|                          | by: Complaint #20365 (A all or in part, in these Based on record revifailed to ensure immer physician and Adult F frequent agitated, agbehaviors that increasinjuring others due to (Resident #7) of 4 (R #14) case mix reside to the Certified Alzhemonths. This failed p           | ew and interview, the facility ediate consultation with Protective Services regarding gressive, and/or intrusive sed risk of being injured or his behaviors for 1 esident #7, #12, #13 and ents who were was admitted imer Care Unit in the past 6 ractice resulted in Immediate ed or could have caused or possible death for |                     |   |  |                            |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |  | (X2) MULTIPLE CONSTRUCTION  A. BUILDING   |                     |  | (X3) DATE SURVEY<br>COMPLETED   |          |                            |
|---|--|---|---------------------|--|---|----------|----------------------------|
|   |  | 045189  | B. WING             |  |   | 07/      | 27/ <b>2015</b>            |
|   | ROVIDER OR SUPPLIER  |   |                     | STREET ADDRESS, CITY, STA<br>900 MAGNOLIA RD<br>CAMDEN, AR 71701 | -<br>ATE, ZIP CODE  | <u> </u> | 27/2015                    |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIENC  | ATEMENT OF DEFICIENCIES<br>BY MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | (EACH CORREC<br>CROSS-REFEREN                                    | PLAN OF CORRECTION<br>CTIVE ACTION SHOULD BE<br>ICED TO THE APPROPRIA<br>EFICIENCY) |          | (X5)<br>COMPLETION<br>DATE |
| F 157   | 19 residents who res Alzheimer's Unit as of Jeopardy was remove at 7:00 a.m. and the "H" when the facility initiated corrective acond correct the under time of the survey. The Immediate Jeopa 5:15 p.m. The finding 1. Resident #7 was a 4/6/15 with diagnose Behavioral Disturbant and Insomnia.  The History and Physic geri-psych unit dated Admit Date: 03/13/3 a psych unit in Little I and/or taking food from Concern was expression an acute unit and facility, he has been a beds and take their cabsolutely unavailably time "The Dischard documented, "Princip behavioral disturband Schizophrenia. The Patient arrived as a reonfusion and inabilitias a tendency to be sat that Psychiatric fact was at risk for being at that facility were yet. | d had the potential to affect ided on the Certified of 7/21/15. The Immediate ed by the facility on 7/21/15 scope/severity reduced to identified the issue and ction however the facility did lying deficient practice at the ne facility was informed of ordy removed on 7/24/15 at its are:  admitted to the facility on so of Dementia with ce, Schizophrenia, Anxiety  sical Report from the 3/13/15 documented, "2015He apparently was in Rock and he was aggressive on other people's trays? sed that he might be harmed was sent to Geri unit. At this noted to lay on other people dothing. Any other history is e to this physician at this rige Summary dated 4/6/15 be Diagnosis: Dementia with ces Secondary Diagnoses Reason for Hospitalization: eferral from [Hospital] due to be to care for himself as well so intrusive with other clients chility that staff there felt he beaten as most of the clients ounger than the client. Item was admitted to our unit | F                   | 157  |   |          |                            |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |  | (X2) MULT<br>A. BUILDIN   | IPLE CONSTRUCTION  IG |  | (X3) DATE SURVEY COMPLETED |                            |
|---|--|---|-----------------------|--|----------------------------|----------------------------|
|   |  | 045189  | B. WING _             |  |                            | C<br>07/27/2015            |
|   | ROVIDER OR SUPPLIER S HEALTH AND REHA  | BILITATION, LLC   |                       | STREET ADDRESS, CITY, STATE, ZIP CODE 900 MAGNOLIA RD CAMDEN, AR 71701                 | <b></b>                    | 0112112013                 |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIEN   | STATEMENT OF DEFICIENCIES<br>CY MUST BE PRECEDED BY FULL<br>R LSC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG   | PROVIDER'S PLAN OF COR ( (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY) | SHOULD BE                  | (X5)<br>COMPLETION<br>DATE |
| F 157   | tendency to not take   | ease of agitation as well as a element in the medication despite  | F 1                   | 57   |                            |                            |
|   | the patient remained intrusive and difficul  | e increasing doses of Haldol<br>d, he is easily agitated and<br>t to redirect and eventually<br>ability issues with the Haldol in   |                       |  |                            |                            |
|   | Assessment Refere documented the res severely impaired) of Mental Status (BIMS had wandering behave required limited assimobility, transfers, a and personal hygier incontinent of bowel was 75 inches (6 for received Antianxiety medicati  | num Data Set (MDS) with noce Date (ARD) 7/13/15 ident scored 3 (0-7 indicates on the Brief Interview for S); had a mood score of 0; aviors that occurred daily; istance of 1 person for bed ambulation in room or corridor ne; was occasionally and bladder; had no pain; ot 2 1/2 inches) in height; and offic, Antidepressant and ion 7 of the past 7 days. The las APS (Adult Protective |                       |  |                            |                            |
|   | documented, "On 4 admitted to [facility runit LTC [long term   | tes dated 4/7/15 at 1:12 a.m.<br>/6/15 10 p.m. Resident<br>name] secured Alzheimer's<br>care] bed He is ambulatory<br>rridors with slow and steady  |                       |  |                            |                            |
|   | days) documented to fincreased agitation intrusiveness that remedication. The Dedocument consultations agitation in the second of the second o | tes from 4/7/15-4/30/15 (23 he resident had 11 episodes on, aggression, and/or equired PRN (as needed) epartmental Notes did not ion with physician and APS increased risk of being injured e to his behaviors:   |                       |  |                            |                            |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTR AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  A. BUILDING |  |   |                     | DATE SURVEY<br>COMPLETED   |          |                            |
|---|--|---|---------------------|--|----------|----------------------------|
|   |  | 045189  | B. WING             |  |          | C<br><b>07/27/2015</b>     |
|   | ROVIDER OR SUPPLIER  | 1   |                     | STREET ADDRESS, CITY, STATE, ZIP CODE 900 MAGNOLIA RD CAMDEN, AR 71701                               | <u> </u> | 0112112013                 |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIENC  | TATEMENT OF DEFICIENCIES<br>CY MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRE<br>(EACH CORRECTIVE ACTION SH<br>CROSS-REFERENCED TO THE APP<br>DEFICIENCY) | IOULD BE | (X5)<br>COMPLETION<br>DATE |
| F 157   | Continued From pag   | e 4   | F 15                | 7  |          |                            |
|   | documented, "Resident enter and disturbing them redirected and divertand drinks. Diversio pacing and exit se [milligrams] IM [intra 2) Departmental Not documented, "On 4/6 is becoming verbally other residents. He selse I will hold you in will be put in jail for resident at a female redon't say a word or I medicated with Hald awake wandering and soda from a female redon't say a word or I medicated with Hald awake wandering and soda from a female redon't say and telling female resay anything. Attempseat and he states resident wander with seated himself at tabing IM right deltoid."  Departmental Notes documented, "New [Physician] derease mg at hs [hour of sle Zyprexa, give Seroq | es dated 4/9/15 at 2:17 a.m. B/15 at 3:00 p.mResident aggressive with staff and states, 'If you say anything a contempt of court and you no less than 9 days.' He sident states 'Sit down and will put you in jail.' Resident ol 5 mg IM. At 7:15 p.m. bound in dining room takes a resident she asks him to put profanity."  es dated 4/10/15 at 12:26 On 4/9/15 at 6:00 p.m. wring around the dining room sident to sit down and do not bots to redirect resident to his Stop talking ' staff let a close supervision until he ole 6:30 p.m Haldol 5  dated 4/10/15 at 3:06 p.m. w orders received from [decrease] Trazadone to 150 |                     |  |          |                            |

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|--|---|---|---------------------|---|---------------|--|
|  |   | 045189  | B. WING             |   | 07/27/2015    |  |
|  | ROVIDER OR SUPPLIER   | ABILITATION, LLC  | 90                  | TREET ADDRESS, CITY, STATE, ZIP CODE<br>DO MAGNOLIA RD<br>AMDEN, AR 71701   | 1 01/2/12010  |  |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIE   | STATEMENT OF DEFICIENCIES<br>NCY MUST BE PRECEDED BY FULL<br>IR LSC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD I<br>CROSS-REFERENCED TO THE APPROPR<br>DEFICIENCY) | BE COMPLETION |  |
| F 157  | documented, "On Resident went to seated in her w/c [vidid you get my chapresent and states turns to resident dalie." Staff redirects Haldol 5 mg IM for agitation/aggressiva female room and was redirected by swith redirection"  5) Departmental Nop.m. at 7:30 p.m. dopushed the west excausing the alarm sum. Haldol 5 mg IM.'  6) Departmental Nop.m. documented, verbally abusive to Administered Loraz 2130 [9:30 p.m.]  7) Departmental Nop.m. documented, hallways and other various objects and Resident got hold distarted pushing it of 3 attempted to get became combative had better get awa away from cart compressions. | otes dated 4/11/15 at 1:01 a.m. 4/10/15 at 4:45 p.m. tand over female resident wheelchair] and asks her 'Why ir' resident daughter remains , 'No that her w/c.' resident aughter and states, "You are a across the hall for privacy increased eness. 7:30 p.m. Resident is in refuses to leave room. He staff after 15 minutes spent otes dated 4/13/15 at 10:28 ocumented, "resident kit door open to the courtyard to sound. Resident redirected of the staff after 15 minutes at 10:44 "Resident up pacing hallway residents and staff. Eepam 2 mg IM in left hip at | F 157               |   |               |  |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |  | I ' '  | PLE CONSTRUCTION  3 | l\ /   | (X3) DATE SURVEY COMPLETED |                            |  |
|---|--|--|---------------------|--|----------------------------|----------------------------|--|
|   |  | 045189   | B. WING             |  |                            | C<br>07/27/2015            |  |
|   | ROVIDER OR SUPPLIER  | BILITATION, LLC  |                     | STREET ADDRESS, CITY, STATE, ZIP CODE  900 MAGNOLIA RD  CAMDEN, AR 71701           | 1                          | 7112112013                 |  |
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| F 157   | 1200 Lorazepam 1 much difficulty."  8) Departmental No documented, "4/22/turned to water on ir placed a trash can it to fill the sink overfice [number] bedroom voorridor. He is wand room removing their other items he the meal He refused to aggressive with staff Haldol 5 mg IM right.  Departmental Notest documented, "Residoor this morning, a when staff attempte [Physician] notified, Lorazepam 1 mg por [hours] prn agitation 3:34 p.m. document facility on 4/30/15 and adjustments.  9) Departmental No at 11:00 a.m. documented and started eye wash station. He knocking out a paner Resident medicated [right] arm for agitation 10) Departmental No p.m. documented, " | y and physically aggressive.  Ing IM given x 3 staff with  Ites dated 4/23/15 at 4:14 p.m.  Ites dated 4/23/15 at determine the sink causing the water owing the bathroom and room which then flowed out into the dering into other residents walkers, trash cans, and en was served alternate of eat became verbally for the was medicated with deltoid."  Independent of the water owing the water owing the bathroom and room which then flowed out into the dering into other residents walkers, trash cans, and en was served alternate of eat became verbally for the was medicated with deltoid."  Independent of the water owing th | F 15                | 57   |                            |                            |  |

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|  | ROVIDER OR SUPPLIER  |  |                      | STREET ADDRESS, CITY, STATE, ZIP COD<br>900 MAGNOLIA RD<br>CAMDEN, AR 71701                | •                             | 07/27/2015                 |
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| F 157  | [agitation] noted to be refuses to go into dir 'there's bad people is given po at this time.  11) Departmental Nota.m. documented, "back and forth in half increase agitation with Ativan [Lorazepam] ml (1 mg) IM given  c. Departmental Not Medication Administ  | e increased at this time. R hing room and eat, stating h there.' Lorazepam 1 mg"  otes dated 4/30/15 at 2:18 1:00 a.m. Resident up pacing lways not easily redirected hen redirecting resident. 2 mg/ml carpuject inject 0.5 "  es and the May 2015 ration Record (MAR) from                   | F 1                  | 57   |                               |                            |
|  | resident had 24 epis aggression, and/or in PRN medication. The Physician Progression consultation with the regarding resident in or injuring others due to the progression of the progre | creased risk of being injured<br>e to his behaviors<br>es dated 5/2/15 at 10:59 p.m.<br>00 a.m. resident pacing back   |                      |  |                               |                            |
|  | trying to hit staff and administered. At 170 pacing back and fort [angry] balling fist ar residents. Lorazepar 2) Departmental Not documented, "at 1 pacing back and fort [angry], balling fist a residents. Lorazepar   | very anger, balling fist and residents. Lorazepam 2 mg 10 [5:00 p.m.] Resident h in hallway, very anger and trying to hit staff and m 2 mg administer[ed]"  es dated 5/2/15 at 10:59 p.m. 700 [5:00 p.m.] resident h in hallway, very anger and trying to hit staff and m 2 mg administer[ed]" |                      |  |                               |                            |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |  | ' '  | E CONSTRUCTION      | COMPLETED  |                 |  |
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|   | ROVIDER OR SUPPLIER  | BILITATION, LLC  | ,                   | STREET ADDRESS, CITY, STATE, ZIP CODE<br>900 MAGNOLIA RD<br>CAMDEN, AR 71701                           | 1 0112112013    |  |
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| F 157   | the resident was add p.o. for increased age 4) The back of the Mathematical the resident was add p.o. for increased age 5) Departmental Nordocumented, "2:45 phallways not easily a Ativan 1 mg 1 tab po 6) Departmental Nordocumented, "5:30 a attempting to wander redirected Increase given."  7) Departmental Nordocumented, "0915 extreme agitation at he will not leave thir [Resident] noted tryithe unit as another for does daily. R nonco Lorazepam 2 mg/ml IM given at this time. Departmental Notes "1100 [11:00 a.m.]-Fhis room in another on. R in other reside water to the point of back to his room"  8) Departmental Nordocumented, "Residented, "Residented, "Residented own hallways. Inatted the point of back to his room" | ministered Lorazepam 1 mg gitation on 5/4/15 at 6:15 p.m.  May 2015 MAR documented ministered Lorazepam 1 mg gitation on 5/5/15 at 1030.  May 2015 MAR documented ministered Lorazepam 1 mg gitation on 5/5/15 at 1030.  May 2015 MAR documented ministered Lorazepam 1 mg gitation on 5/5/15 at 1030.  May 2015 MAR documented ministered Lorazepam 1 mg gitation on 5/5/15 at 3:54 a.m.  May 2015 MAR documented ministered Lorazepam 1 mg gitation A.m.  May 2015 MAR documented ministered Lorazepam 1 mg gitation A.m.  May 2015 MAR documented ministered Lorazepam 1 mg gitation on 5/5/15 at 1030.  May 2015 MAR documented ministered Lorazepam 1 mg gitation on 5/5/15 at 1030.  May 2015 MAR documented ministered Lorazepam 1 mg gitation on 5/5/15 at 1030.  May 2015 MAR documented ministered Lorazepam 1 mg gitation on 5/5/15 at 1030.  May 2015 MAR documented ministered Lorazepam 1 mg gitation on 5/5/15 at 1030.  May 2015 MAR documented ministered Lorazepam 1 mg gitation on 5/5/15 at 1030.  May 2015 MAR documented ministered Lorazepam 1 mg gitation on 5/5/15 at 1030.  May 2015 MAR documented ministered Lorazepam 1 mg gitation on 5/5/15 at 1030.  May 2015 MAR documented ministered Lorazepam 1 mg gitation on 5/5/15 at 1030.  May 2015 MAR documented ministered Lorazepam 1 mg gitation on 5/5/15 at 1030.  May 2015 MAR documented ministered Lorazepam 1 mg gitation on 5/5/15 at 1030.  May 2015 MAR documented ministered Lorazepam 1 mg gitation on 5/5/15 at 1030.  May 2015 MAR documented ministered Lorazepam 1 mg gitation on 5/5/15 at 1030.  May 2016 MAR documented ministered Lorazepam 1 mg gitation on 5/5/15 at 1030.  May 2016 MAR documented ministered Lorazepam 1 mg gitation on 5/5/15 at 1030.  May 2016 MAR documented ministered Lorazepam 1 mg gitation on 5/5/15 at 1030.  May 2016 MAR documented ministered ministered Lorazepam 1 mg gitation on 5/5/15 at 1030.  May 2016 MAR documented ministered minis | F 157               |  |                 |  |

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| F 157  | increase in agitation"  9) Departmental Nordocumented, "Resident weasily redirected to light when trying to dress 1 tab po given"  10) Departmental Nat 11:59 a.m. docum of resident's rooms of turning water on not noted to be incontinapproached him for very resistive and be Male staff arrived and 12:30[p.m.] Ativan 1  11) The back of the the resident was adip.o. for increased age 12) Departmental National Male staff arrived and p.o. for increased age 12) Departmental National Male staff arrived and p.o. for increased age 12) Departmental National Male staff arrived and p.o. for increased age 12) Departmental National Male staff arrived and p.o. for increased age 12) Departmental National Male staff and p.o. for increased age 12) Departmental National Male staff and p.o. for increased age 13) Departmental National Male staff and p.o. for increased age 13) Departmental National Male staff and p.o. for increased age 13) Departmental National Male staff and p.o. for increased age 13) Departmental National Male staff and p.o. for increased age 13) Departmental National Male staff and p.o. for increased age 13) Departmental National Male staff arrived ar | it up. Not easily redirected Ativan 1 mg 1 tablet given po  tes dated 5/8/15 at 6:02 a.m. Ident wandering in dining room and anything that is on the ill not put on clothing and not his room. Increased agitation is him or redirect. Ativan 1 mg  otes Addendum dated 5/8/15 hented, "Resident in and out going in bathrooms and easily redirected. Resident ent of bowel, when staff toileting and peri-care he's ecame slightly combative. Ind peri-care given per 3 staff. Img po given"  May 2015 MAR documented ministered Lorazepam 1 mg gitation at 7:00 p.m. on 5/8/15.  otes dated 5/8/15 at 4:44 a.m. In [p.m.] Resident up In diaper on head and no directed increase in agitation esident go back to room. In given po"  otes dated 5/9/15 at 6:05 a.m. In the fresident taking clothes | F 18                | 57  |                 |  |
|  | off and on in room. I<br>over room. Has diap<br>wrong way. Resider  | Resident as [has] clothing all per on head and shirt on all urinating outside door. Not given"  |                     |   |                 |  |

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|   |   | 045189   | B. WING             |   |           | C<br><b>07/27/2015</b>     |  |  |
|   | ROVIDER OR SUPPLIER   | BILITATION, LLC  |                     | STREET ADDRESS, CITY, STATE, ZIP CODE<br>900 MAGNOLIA RD<br>CAMDEN, AR 71701                    | <b>,</b>  | 0772772010                 |  |  |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIEN  | TATEMENT OF DEFICIENCIES<br>CY MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF COR<br>(EACH CORRECTIVE ACTION S<br>CROSS-REFERENCED TO THE A<br>DEFICIENCY) | SHOULD BE | (X5)<br>COMPLETION<br>DATE |  |  |
| F 157   | Continued From pag  | ge 10  | F 15                | 7   |           |                            |  |  |
|   | the resident was adr  | May 2015 MAR documented ministered Lorazepam 1 mg pitation at 7:00 p.m. on   |                     |   |           |                            |  |  |
|   | from table to table in<br>the water at the sink<br>and other residents.<br>and food but continu   | otes dated 5/13/15  Resident is up wandering the dining room, turning on becoming loud with staff. He is redirected with fluids les with behavior escalation. In Ativan 1 mg 2 po"   |                     |   |           |                            |  |  |
|   | the resident was adr  | May 2015 MAR documented ministered Lorazepam 1 mg gitation on 5/16/15 at 1940  |                     |   |           |                            |  |  |
|   | the resident was adr  | May 2015 MAR documented ministered Lorazepam 1 mg gitation on 5/17/15 at 1610  |                     |   |           |                            |  |  |
|   | p.m. documented, "observed standing a out at parking lot, he and needs to go get window, multiple atta away from window became severely ag aggressive. At 10:30 Lorazepam 0.5 ml 1 resident became extand unable to give on | otes dated 5/21/15 at 4:04 1000 [10 a.m.] Resident t window in kitchen looking e said he see his car out there it, he attempted to open empts per staff to divert him before he complied, then he itated with staff and verbally o a.m. attempted to give mg IM per assist x 3 staff, remely agitated and resistive omplete dose Lorezpam 1 en without incident" |                     |   |           |                            |  |  |
|   | 19) Departmental No   | otes dated 5/21/15 at 11:42  |                     |   |           |                            |  |  |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: |   | (X2) MULTI<br>A. BUILDIN  | PLE CONSTRUCTION  G |  | (X3) DATE SURVEY COMPLETED |                            |  |
|--|---|---|---------------------|--|----------------------------|----------------------------|--|
|  |   | 045189  | B. WING _           |  |                            | C<br>07/27/2015            |  |
|  | ROVIDER OR SUPPLIER   | BILITATION, LLC   |                     | STREET ADDRESS, CITY, STATE, ZIP CODE<br>900 MAGNOLIA RD<br>CAMDEN, AR 71701             |                            | 0772772013                 |  |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIEN  | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY) | SHOULD BE                  | (X5)<br>COMPLETION<br>DATE |  |
| F 157  | Continued From pag  | ge 11<br>7:00 p.m. He is medicated  | F 1                 | 57   |                            |                            |  |
|  | with Ativan 1 mg 1 p  | o for increased agitation<br>to assist with changing of his   |                     |  |                            |                            |  |
|  | a.m. documented, "<br>0.5mg im [IM] for be<br>[agitated] and trying<br>resident froom [roon   | ration Record (MAR)   |                     |  |                            |                            |  |
|  | a.m. documented, "window in dining root<br>trying to open it, not<br>dining room and beg  | otes dated 5/22/15 at 11:18<br>1045 Resident observed at<br>om pulling up on window and<br>easily diverted. Resident left<br>gan pacing in hallways and<br>nd window of Nursing Station.<br>given"  |                     |  |                            |                            |  |
|  | p.m. documented, "s<br>resident has been p<br>residents rooms and<br>became agitated wit  | otes dated 5/25/15 at 1:46 Since out of bed this morning acing, going in other I getting their belongings, he h staff when redirected. given at 11:30 a.m"  |                     |  |                            |                            |  |
|  | p.m. documented, "6 pacing in the corrido wandering in other r [room #33] states he [Resident #7] back i Director of Nurses] v [room #33] concerns his room. At 7:00 p.m. | otes dated 5/25/15 at 11:35 6:40 p.m. Resident up and ors. He has behavior of esidents rooms. Resident in the doesn't want this resident on his room. ADON [Assistant was notified of the resident in the soft this resident coming into orm. Resident has wandered redirecting him he became |                     |  |                            |                            |  |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |   | (X2) MULTIPLE CONSTRUCTION  A. BUILDING  |                     |  | (X3) DATE SURVEY<br>COMPLETED |                            |
|---|---|--|---------------------|--|-------------------------------|----------------------------|
|   |   | 045189   | B. WING             |  |                               | C<br><b>07/27/2015</b>     |
|   | ROVIDER OR SUPPLIER   |  |                     | STREET ADDRESS, CITY, STATE, ZIP CODE 900 MAGNOLIA RD CAMDEN, AR 71701                               |                               | 0/12/12015                 |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIENC   | TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRE<br>(EACH CORRECTIVE ACTION SH<br>CROSS-REFERENCED TO THE APP<br>DEFICIENCY) | OULD BE                       | (X5)<br>COMPLETION<br>DATE |
| F 157   | agitated states, 'Jus resident sandwich ar him with Ativan 1 mg with resident [#7] und room"  Departmental Notes documented, "Reside going into other resident closets and drawers activities/food/fluids. increasingly agitated [Physician] with new Seroquel to 50 mg in notified of new order  Departmental Notes documented, "[Physi resident with no new Physician Progress Mocumented, "HPI [hinformation]/Social Hto psych facility for A aggressively taking for trays. Because of his felt that there might being placed in acute admitted to the Geria been reported that hoother peoples' beds Beyond that, I can't geems to have done reduction on the mediaking. At this point responds with the swibid [twice daily]" | t leave me alone', staff gave and sweet tea and medicated po. Staff remains in room 34 til he agrees to go to his dated 5/27/15 at 3:44 p.m. ent pacing hallways and dents rooms pilfering in Attempts to redirect with Resident becomes towards staff. Call placed to orders received to increase am and 100 mg hs. [APS] s"  dated 5/28/15 at 4:34 p.m. cian] here to examine orders received."  Notes dated 5/28/15 istory and physical listory:He was transferred PS related issue. He was ood from other patient's aggressive behavior, it was be some issues with him er care unit, so he was atric Unit at this facility. It had the was found on occasion on removing their clothes. Get much elsePlan: He | F 15                | 57   |                               |                            |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: |   | (X2) MULTIF<br>A. BUILDING  | PLE CONSTRUCTION    |  | (X3) DATE SURVEY<br>COMPLETED |                            |
|---|---|---|---------------------|--|-------------------------------|----------------------------|
|   |   | 045189  | B. WING             |  |                               | C<br><b>07/27/2015</b>     |
|   | ROVIDER OR SUPPLIER   | BILITATION, LLC   |                     | STREET ADDRESS, CITY, STATE, ZIP CODE 900 MAGNOLIA RD CAMDEN, AR 71701                           | 1                             |                            |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIENC   | TATEMENT OF DEFICIENCIES<br>CY MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORI<br>(EACH CORRECTIVE ACTION S<br>CROSS-REFERENCED TO THE A<br>DEFICIENCY) | SHOULD BE                     | (X5)<br>COMPLETION<br>DATE |
| F 157   | Continued From pag  | ne 13   | F 15                | 57   |                               |                            |
|   | Lorazepam 2 mg IM [agitation]."  d. Departmental Nor Medication Administration 6/1/15 - 6/30/15 (30 resident had 13 epis aggression, and/or in PRN medication. The document consultation regarding resident in or injuring others due 1) Departmental Not documented, "At 143 in eyewash room, has smeared it on cabine refused to change his assist him, he becan threatening. Lorazep 2) The back of the Juthe resident was adr IM for behavior on 6/4) The back of the Juthe resident was adr IM for behavior agita a.m.).  5) The back of the Juthe resident was adr IM for behavior agita a.m.). | tes and the June 2015 ration Record (MAR) from days) documented the odes of increased agitation, ntrusiveness that required e Departmental Notes did not on with physician and APS acreased risk of being injured e to his behaviors:  es dated 6/1/15 4:10 p.m. 30 [2:30 p.m.] Resident went ad BM [bowel movement] ets and is clothing. He as clothes or allow staff to one verbally and physically |                     |  |                               |                            |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |  | (X2) MULTIF  | PLE CONSTRUCTION    |  | (X3) DATE SURVEY<br>COMPLETED |                            |  |
|---|--|--|---------------------|--|-------------------------------|----------------------------|--|
|   |  | 045189   | B. WING             |  | 0                             | C<br><b>7/27/2015</b>      |  |
|   | ROVIDER OR SUPPLIER  S HEALTH AND REHAE  | BILITATION, LLC  |                     | STREET ADDRESS, CITY, STATE, ZIP CODE 900 MAGNOLIA RD CAMDEN, AR 71701                   | ' '                           | .,,_                       |  |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIENC  | TATEMENT OF DEFICIENCIES<br>CY MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY) | SHOULD BE                     | (X5)<br>COMPLETION<br>DATE |  |
| F 157   | Continued From pag   | e 14   | F 15                | 57   |                               |                            |  |
|   | the resident was adn   | une 2015 MAR documented ninistered Lorazepam 1 mg itation on 6/17/15 at 10:45  |                     |  |                               |                            |  |
|   | the resident was adn   | une 2015 MAR documented ninistered Lorazepam 1 mg itation on 6/19/15 at 4:30   |                     |  |                               |                            |  |
|   | the resident was adn   | une 2015 MAR documented<br>ninistered Lorazepam 1 mg<br>tion on 6/21/15 at 2202  |                     |  |                               |                            |  |
|   | the resident was adn   | une 2015 MAR documented ninistered Lorazepam 1 mg itation on 6/23/15 at 10:45  |                     |  |                               |                            |  |
|   | the resident was adn   | June 2015 MAR documented ninistered Lorazepam 1 mg itation on 6/23/15 at 3:30  |                     |  |                               |                            |  |
|   | the resident was adn   | June 2015 MAR documented ninistered Lorazepam 1 mg itation on 6/26/15 at 9:30  |                     |  |                               |                            |  |
|   | documented, "4:20 pass staff he caught around her left wrist, resident to released dining room for food to be verbal aggress | otes dated 6/26/15 11:52 p.m. p.m. Resident was walking her left arm holding tightly verbal cueing from staff to staff arm then redirected to and fluid. Resident continues ive to staff and other icated with Ativan 1 mg po. " |                     |  |                               |                            |  |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |  | (X2) MULTI<br>A. BUILDIN   | PLE CONSTRUCTION  G |  | (X3) DATE SURVEY<br>COMPLETED |                            |
|---|--|--|---------------------|--|-------------------------------|----------------------------|
|   |  | 045189   | B. WING             |  |                               | C<br>07/27/2015            |
|   | ROVIDER OR SUPPLIER  | BILITATION, LLC  |                     | STREET ADDRESS, CITY, STATE, ZIP CODE 900 MAGNOLIA RD CAMDEN, AR 71701                           |                               | 0112112013                 |
| (X4) ID<br>PREFIX<br>TAG  |  |  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORI<br>(EACH CORRECTIVE ACTION S<br>CROSS-REFERENCED TO THE A<br>DEFICIENCY) | SHOULD BE                     | (X5)<br>COMPLETION<br>DATE |
| F 157   | the resident was ad p.o. for increased at a.m.  e. Departmental No Medication Adminis 7/1/15 - 7/16/15 (16                             | ge 15 June 2015 MAR documented ministered Lorazepam 1 mg gitation on 6/27/15 at 11:40 otes and the July 2015 tration Record (MAR) from days) documented the odes of increased agitation,                       | F 1                 | 57   |                               |                            |
|   | aggression, and/or i<br>PRN medication. The<br>document consultate<br>regarding resident in<br>or injuring others du                   | intrusiveness that required<br>ne Departmental Notes did not<br>ion with physician and APS<br>ncreased risk of being injured   |                     |  |                               |                            |
|   | the resident was ad  | ministered Lorazepam 1 mg<br>gitation on 7/01/15 at 3:00   |                     |  |                               |                            |
|   | documented, "10:3<br>resident observed of<br>hallways, going in m<br>bothering them. Res<br>manic like mode wit<br>threatening towards | tes dated 7/2/15 10:32 a.m. 0 a.m. Ativan 1 mg po given, over past hour pacing in hale residents room and sident talking non-stop in h speech becoming some staff. All attempts to with activities snacks, 1-1 |                     |  |                               |                            |
|   | the resident was ad  | luly 2015 MAR documented<br>ministered Lorazepam 1 mg<br>gitation on 7/4/15 at 9:15 a.m.   |                     |  |                               |                            |
|   | the resident was ad  | luly 2015 MAR documented<br>ministered Lorazepam 1 mg<br>gitation on 7/5/15 at 9:00 a.m.   |                     |  |                               |                            |
|   | 5) The back of the J   | luly 2015 MAR documented   |                     |  |                               |                            |

|                          |   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  |                     |     | CONSTRUCTION   | (X3) DATE SURVEY<br>COMPLETED |                            |
|--------------------------|---|---|---------------------|-----|--|-------------------------------|----------------------------|
|                          |   | 045189  | B. WING _           |     |  |                               | 27/ <b>2015</b>            |
|                          | ROVIDER OR SUPPLIER S HEALTH AND REHAB  | ILITATION, LLC  |                     | 900 | REET ADDRESS, CITY, STATE, ZIP CODE  MAGNOLIA RD  MDEN, AR 71701   | 1 011                         | 2172010                    |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC   | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION)   | ID<br>PREFII<br>TAG | ×   | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD B<br>CROSS-REFERENCED TO THE APPROPRI<br>DEFICIENCY) |                               | (X5)<br>COMPLETION<br>DATE |
| F 157                    | Continued From page   |   | F ·                 | 157 |  |                               |                            |
|                          |   | iinistered Lorazepam 1 mg<br>tation on 7/8/15 at 11:30  |                     |     |  |                               |                            |
|                          | documented, "10:45 morning in agitated n tone of voice when st and to dining room for   | es dated 7/16/15 at 3:19 p.m. a.m. Resident woke up this nood, pacing with angry of aff cues him for redirections r breakfast. Resident made t did not make contact.  |                     |     |  |                               |                            |
|                          | documented, "6:30 a at Nurse's station stame." this nurse follow found [Resident #8] stated swelling to right could not state what [Resident #7] stated, asked did resident his stated, "I kicked her Resident did this resistated, "No." This Nuinto Nurses Station. If denies any pain 0 on [range of motion] in LE [lower extremities resident. Resident warm [IM] given to right call MD notified of Attempted to notify [Alanswering machine." 1:1 form dated 7/21/1 | 'She attacked me.' In ther, he [Resident #7] in the face.' When asked dent [Resident #8] hit him he rese separated the resident Resident [Resident #7] pain scale 1-10. Full ROM JE [upper extremities] and Je No noted blood on as given Ativan 2 mg/ml 0.5 gluteus medius Called on incident 6:55 a.m. APS worker #1] and only A Continuous Monitoring 5 documented the facility on 1 monitoring of resident at |                     |     |  |                               |                            |
|                          | Resident #8, a 102 y  | ear old female, had   |                     |     |  |                               |                            |

| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION |   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   | (X2) MULTIPL<br>A. BUILDING | E CONSTRUCTION   | (X3) DATE SURVEY COMPLETED |  |
|---|---|--|-----------------------------|--|----------------------------|--|
|   |   | 045189   | B. WING                     |  | C<br>07/27/2015            |  |
|   | ROVIDER OR SUPPLIER  S HEALTH AND REHA  | BILITATION, LLC  |                             | STREET ADDRESS, CITY, STATE, ZIP CODE<br>900 MAGNOLIA RD<br>CAMDEN, AR 71701                               | , 3,,2,,20,10              |  |
| (X4) ID<br>PREFIX<br>TAG                            | (EACH DEFICIE)  | STATEMENT OF DEFICIENCIES<br>NCY MUST BE PRECEDED BY FULL<br>R LSC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG         | PROVIDER'S PLAN OF CORRECT<br>(EACH CORRECTIVE ACTION SHOU<br>CROSS-REFERENCED TO THE APPRO<br>DEFICIENCY) | LD BE COMPLETION           |  |
| F 157   | Notes dated 7/21/1 resident was sent to (ER). Departmental a.m. documented, from ER facial fract maxillary fracture  g. Departmental Notand signed Alzheim (ACUD) documented p.m. this Nurse tool monitoring to reliev was ambulating up went into the room had difficulty redired. He was exhibiting slingo" when speakin open the door he will grabbed my wrist street will find you have redirected and back became increasing. He opened the dool entered and I was at the room. [Residen shoe belonging to the entered and the two aggressive towards for help to redirect [DON] was able to get the content of the procession of the pr | mer's disease. Departmental 5 at 7:27 a.m. documented the of the hospital emergency room all Notes date 7/21/15 at 11:24 "Discharge dx [diagnosis] ure. Right orbital and right "  Inter a Care Unit Director and any and down hallway. Resident wo female residents and I acting him to leave the room. Iternness and reverting to "coping to me. I attempted to hold as trying to shut and he tating. 'I will murder you and anying in the trees.' Once a into hallway, resident by agitated and inconsolable. It to another resident 's room, anable to redirect him out of a trying reached down to grab a the resident of the room he or resident became verbally another and I had to call a fresident #7]. The [Name] DON entered the room. The get [Resident #7] attention and | F 157                       | ,  |                            |  |
|   | increasingly agitate<br>Ativan 1 mg that the<br>#7] became increas<br>staff and several staff<br>"scared" of him at the   | om. [Resident #7] became d, would not take the oral e LPN was offering. [Resident singly verbally threatening to aff members stated they were his point. He was not able to sought guidance from the   |                             |  |                            |  |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |  | (X2) MULT<br>A. BUILDIN   | PLE CONSTRUCTION  IG | . ,   | (X3) DATE SURVEY<br>COMPLETED |                            |
|---|--|---|----------------------|---|-------------------------------|----------------------------|
|   |  | 045189  | B. WING _            |   |                               | C<br>07/27/2015            |
|   | ROVIDER OR SUPPLIER  S HEALTH AND REHA   | BILITATION, LLC   |                      | STREET ADDRESS, CITY, STATE, ZIP CODE 900 MAGNOLIA RD CAMDEN, AR 71701                              | <u>'</u>                      | 3172172313                 |
| (X4) ID<br>PREFIX<br>TAG  |  |   | ID<br>PREFIX<br>TAG  | PROVIDER'S PLAN OF CORRI<br>(EACH CORRECTIVE ACTION SH<br>CROSS-REFERENCED TO THE AP<br>DEFICIENCY) | HOULD BE                      | (X5)<br>COMPLETION<br>DATE |
| F 157   | send him to ER. The ambulance was dispose several staff member calm down and get of all and get of all and geri-psych. Facility was given Ativar muscle. Phone [APS message. ER call and [Resident#7] back to [APS Worker #1] and geri-psych. Facility was peri-psych. Facility was been considered by the resident was train p.m.  h. On 7/24/15 licens was asked if she wood alzheimer Unit. The years. "The LPN was asked if she wood alzheimer Unit. The years. "The LPN was able to compeople. He got agitate pick up things. "The periods that he would then all of a sudder the sudder the periods that he would then all of a sudder the sudder the periods that he would then all of a sudder the | was told to call ambulance and the ER was contacted and the patched to the facility. It took ters to get [Resident #7] to conto the stretcher. [Resident in 1 mg IM in right deltoid is Worker #1] and left and stated they were sending to the facility. I spoke with did will seek placement at with her approval of facility "  In dated 7/23/15 documented insferred out of facility at 7:00 and on the Certified LPN stated, "Yes for 3 1/2 as asked what was Resident PN stated, "He would wander esidents' rooms, he had athroom. He had behaviors, introl him better than other atted, he would pace, pilfer and the LPN was asked if Resident to a point that he had to have PN stated, "Yes, there were lid have to be medicated. In his behaviors escalated, | F 1                  | ,   |                               |                            |
|   | she had talked to ar<br>CNAs reported to he<br>was asked if she ha<br>regarding the increa<br>s behaviors. The LP  | om. " The LPN was asked if ayone. The LPN stated the er his behaviors. The LPN d reported to anyone else sed episodes of the resident 'N stated, "Yes, I spoke with e Unit Director." The LPN was   |                      |   |                               |                            |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: |  | 1 ' '   | (X2) MULTIPLE CONSTRUCTION  A. BUILDING |   | (X3) DATE SURVEY<br>COMPLETED    |                            |  |
|--|--|---|---|---|----------------------------------|----------------------------|--|
|  |  | 045189  | B. WING                                 |   |                                  | C                          |  |
| NAME OF D  | ROVIDER OR SUPPLIER  | 045169  | B. WING_                                | STREET ADDRESS, CITY, STATE, ZIP C  | ODE                              | 07/27/2015                 |  |
|  |  |   |   | 900 MAGNOLIA RD   | ODE                              |                            |  |
| PINE HILL  | S HEALTH AND REHAB   | ILITATION, LLC  |   | CAMDEN, AR 71701  |                                  |                            |  |
| (X4) ID<br>PREFIX<br>TAG   | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)   |   | ID<br>PREFI)<br>TAG                     | PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC | ION SHOULD BE<br>THE APPROPRIATE | (X5)<br>COMPLETION<br>DATE |  |
| F 157  | Continued From pag   | e 19  | F 1                                     | 157   |                                  |                            |  |
| F 157  | asked what was the of the PRN [as needed] stated, "We try redired with him before we go LPN was asked, "Do when the resident reseveral days and the agitation had increas party notified." The At 10:55 a.m., LPN # on the Certified Alzhe for 1 year. The LPN was times he can become have to redirect him. kind of behaviors did "Verbal threats that he to you. Sometimes he sometimes he required down. "The LPN was did the resident make hit. The LPN was she documented on 5/2/1 did ball up his first and residents." The LPN reported this incident "I can't remember." Thad called the Physic regarding the increas stated, "I can't remer "Do you feel that the behaviors should have | criteria for giving residents medications. The LPN ction, activities, food, 1-to-1 ive the medications. " The id you call the physician beived PRN medication for resident's behaviors of ed and was the responsible LPN stated, "No."  4 was asked if she worked eimer Unit. The LPN stated was asked what was ors. The LPN stated, "At e verbally abusive and you " The LPN was asked what he exhibit. The LPN stated, e was going to do something e would calm down and ed medication to calm him as asked what kind of threats be, did the resident threaten to bown documentation that she 5. The LPN stated, " Yes he did threaten to hit staff and I was asked if she had to anyone. The LPN stated, the LPN was asked if she can or the responsible party seed behaviors. The LPN orber." The LPN was asked, resident 's aggressive we been reported? " The | F1                                      | 157   |                                  |                            |  |
|  | call. " The LPN was documented. The LP documented." The LI   | PN was asked if the other<br>a. The LPN stated, "Not at   |   |   |                                  |                            |  |

|                          |   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  | (X2) MULTIF         | PLE CONSTRUCTION  3   | (X3) DATE SURVEY<br>COMPLETED |  |  |
|--------------------------|---|---|---------------------|---|-------------------------------|--|--|
|                          |   | 045189  | B. WING             |   | C                             |  |  |
| NAME OF P                | ROVIDER OR SUPPLIER   | 043163  | B: Willo            | STREET ADDRESS, CITY, STATE, ZIP CODE   | 07/27/2015                    |  |  |
| NAME OF T                | KOVIDER OR SOLT EIER  |   |                     | 900 MAGNOLIA RD   |                               |  |  |
| PINE HILL                | S HEALTH AND REHAB  | ILITATION, LLC  |                     | CAMDEN, AR 71701  |                               |  |  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC   | ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORREC<br>(EACH CORRECTIVE ACTION SHO<br>CROSS-REFERENCED TO THE APPF<br>DEFICIENCY) | ULD BE COMPLETION             |  |  |
| F 157                    | Continued From page   | e 20  | F 15                | 57  |                               |  |  |
|                          | resident be admitted<br>Unit with a Psychiatri<br>stated, "No." The LPI   | PN was asked should a<br>to the Certified Alzheimer<br>c Diagnosis. The LPN<br>N was asked why. The LPN<br>ld be a potential danger."   |                     |   |                               |  |  |
|                          | At 1:35 p.m., LPN #2 the Certified Alzheim "Yes on the 11-7 shift there were any issue aggressive residents LPN stated, "Yes wi only issue. He was diperiods of agitation at The LPN was asked behaviors were. The out a window, no maday. "The LPN was LPN stated, "I was at [Resident #7] came to stated that somebody followed him back to [Resident #8] sitting ther. I got [Resident #8] out of the ER [Emergency Root came to the Nursing any signs or symptom [Resident #7] what he stated 'I kicked her was asked when did stated, "It occurred a "The LPN was asked aggressive behaviors." | was asked if she worked on er Unit. The LPN stated, t. The LPN was asked if is related to behaviors or on the Alzheimer Unit. The th [Resident #7] that was the bing fine, then he had nd not easily redirected. "what the resident's LPN stated, "He knocked for problems until the other asked what happened. The the Nursing station, to the Nursing Station and the had attacked him. I |                     |   |                               |  |  |
|                          | aggressive behavior<br>The LPN stated, "I wanted the LPN was asked  | that wasn't easily redirected. as at the Nursing Station. " if she could see down the "Not the front hall where   |                     |   |                               |  |  |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION |  | IDENTIFICATION NI IMBED  |                     | 2) MULTIPLE CONSTRUCTION BUILDING |  |       | (X3) DATE SURVEY<br>COMPLETED |  |
|--|--|--|---------------------|-----------------------------------|--|-------|-------------------------------|--|
|  |  | 045189   | B. WING _           |                                   |  | 1     | 27/2015                       |  |
|  | OVIDER OR SUPPLIER  HEALTH AND REHAB   | ILITATION, LLC   |                     | STREET ADDRESS, 900 MAGNOLIA RD   |  | 1 017 | 21/2013                       |  |
| (X4) ID<br>PREFIX<br>TAG                         | (EACH DEFICIENC  | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | (EACH                             | OVIDER'S PLAN OF CORRECTION<br>CORRECTIVE ACTION SHOULD B<br>REFERENCED TO THE APPROPRI<br>DEFICIENCY) |       | (X5)<br>COMPLETION<br>DATE    |  |
|  | was asked if [Resident The LPN stated, "She conce in a blue moon The LPN was asked behaviors at night. The wander at night, he had morning he was getti i. On 7/23/15 at 7:00 (DON) was asked, af documentation regardesident was approprial Alzheimer's Unit. The aware of his history. It was a steed if she resident's aggressive documentation at the DON was asked if she resident's aggressive behaviors residents. "The DON stated, "I was a sin other resident room aggressive behaviors residents." The DON documentation on 5/2 balled up his fist and and other residents. aware." The DON was asked if a reside episodes of aggressive be reported to her. The lawas asked if a reside episodes of aggressive behaviors would put the lake was asked if the increased behaviors would put the lake increased incidents of a state of the lake increased incidents of a state of the lake increased incidents of aggressive behaviors would put the lake increased incidents of a state of the lake increased incidents of a state of the lake increased incidents of a state of the lake increased incidents of aggressive behaviors would put the lake increased incidents of a state of the lake increased incidents of a state of the lake increased incidents of a state of the lake increased incidents of aggressive behaviors would put the lake of the lak | were located. " The LPN Int #8] had any behaviors. It generally didn't wander, did she get up at night. " If Resident #7 had any Ine LPN stated, "He did It ad started sleeping, but that Ing up. "  In p.m., the Director of Nursing Iter reviewing the Iding Resident #7, if this Iter for the Certified In DON stated, "I was not I didn't read the It time of admission. " The Ite was aware of the Ite was aware of the Ite was aware of the Ite was not aware of his Ite towards staff and other | F                   | 57                                |  |       |                               |  |

| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION |  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   | ` ′                 | IPLE CONSTRUCTION IG   | ' '                            | (X3) DATE SURVEY<br>COMPLETED |  |
|---|--|--|---------------------|--|--------------------------------|-------------------------------|--|
|   |  | 045189   | B. WING _           |  |                                | C                             |  |
|   | ROVIDER OR SUPPLIER  |  |                     | STREET ADDRESS, CITY, STATE, ZIP CO<br>900 MAGNOLIA RD<br>CAMDEN, AR 71701   |                                | 7/27/2015                     |  |
| (X4) ID<br>PREFIX<br>TAG                            | (EACH DEFICIEN   | TATEMENT OF DEFICIENCIES<br>CY MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC' | ON SHOULD BE<br>HE APPROPRIATE | (X5)<br>COMPLETION<br>DATE    |  |
| F 157   | behaviors regarding stated, "No." The AC had increased beha medicated who show stated that they show notify the ACUD. The Physician and respondified. The ACUD had been notified with 7/21/15." The ACUD Physician and respondified the resident #7 had incomparty [APS worker # was asked, "What is the Physician of the behaviors?" The AC the resident." The AC oversight on her partrying to transfer the was asked if she had responsible party with the resident. The AC have called for guidal if a resident with Psyschizophrenia, be an Alzheimer Unit. The we are not equipped k. On 7/27/15 at 4:3 asked regarding the dated July 21, 2015 and attached to the Care) Incident and Act and contacted [Physical For [Resident #7]. The had contacted [Physical For [Resident #7]. The sident #7]. | Resident #7. The ACUD CUD was asked if a resident viors that required to be alld they report to. The ACUD alld report to the Nurse and e ACUD was asked if the ansible party should be stated, "Yes. I thought they nen the incident occurred on a was asked was the ansible party notified when reased behaviors. The ACUD not notified the responsible and until 7/23/15. The ACUD at the importance of notifying resident increased UD stated, "For the benefit of CUD stated that this was an at. The ACUD stated, "I was resident out." The ACUD ad called the Physician or the nen she was trying to transfer CUD stated, "No, I should ance." The ACUD was asked archiatric diagnosis, dmitted to the Certified ACUD stated, "I would say | F 1                 | 57   |                                |                               |  |

| STATEMENT OF DEFICIENCIES (X1 AND PLAN OF CORRECTION |   | IDENTIFICATION NUMBER  |                     | PLE CONSTRUCTION  G   | , ,      | (X3) DATE SURVEY COMPLETED |  |
|--|---|--|---------------------|---|----------|----------------------------|--|
|  |   | 045189   | B. WING _           |   |          | C<br><b>07/27/2015</b>     |  |
|  | ROVIDER OR SUPPLIER   | BILITATION, LLC  |                     | STREET ADDRESS, CITY, STATE, ZIP CODE<br>900 MAGNOLIA RD<br>CAMDEN, AR 71701                      |          | 0112112010                 |  |
| (X4) ID<br>PREFIX<br>TAG                             | (EACH DEFICIEN  | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORF<br>(EACH CORRECTIVE ACTION S<br>CROSS-REFERENCED TO THE AI<br>DEFICIENCY) | HOULD BE | (X5)<br>COMPLETION<br>DATE |  |
| F 157  | and that he was very that took place and "How is she? Is she [Physician #1] has a information in attem being placed outside admission. The Adm resident's attending for the referral. The The Administrator we reported to her the fincidents in the resident's in the resident's aggressive behavior "No."  I. On 7/27/15 at 6:38 [Physician #2] was a of Resident #7's inciphysician stated, "O Typically adjust medif he would expect the physician when a rechanges and the phom. On 7/24/15 at 3:4 was asked if Resident #2 was asked if Resident #3 was advised hospital staff after I was advised by [Alz then afterwards. Or hospital called By [7/21/15] he kicked a [Resident #8] I found | ssive behavior at this time y remorseful for the events has repeatedly asked staff, ok? "The letter stated greed to review this pt to prevent resident from the the facility in geri-psych prinistrator was asked if the Physician had given orders asked if the staff had requently documented the staf | F 1                 | 57  |          |                            |  |

|                          | DF DEFICIENCIES<br>CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  | ` '                |         | E CONSTRUCTION  | (X3) DATE SURVEY<br>COMPLETED                |                            |
|--------------------------|---|--|--------------------|---------|---|--|----------------------------|
|                          |   | 045189   | B. WING            | B. WING |   | C<br><b>07/27/2015</b>                       |                            |
|                          | ROVIDER OR SUPPLIER S HEALTH AND REHAB  | ILITATION, LLC   | 1                  | 9       | STREET ADDRESS, CITY, STATE, ZIP CODE<br>100 MAGNOLIA RD<br>CAMDEN, AR 71701                                  | <u>,                                    </u> | 2772013                    |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)  | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)   | ID<br>PREFI<br>TAG |         | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) |  | (X5)<br>COMPLETION<br>DATE |
| F 157                    | Started process for trout Thursday." The Arif aware of other behaviors have been the APS Caseworker about meds and we obehaviors sooner." Tasked if notified of the behaviors that include female resident. The have not been notified aggressive or hitting of the incident yesterday nurse [Emergency Rotthat incident sooner I arrangements to send any aggressive behave 483.13(c) PROHIBIT MISTREATMENT/NE | anty] Sheriff office transport. It ansport as soon as found IPS Caseworker was asked It avior incidents could any Itaken with Resident #7 and IPS Caseworker was IPS Caseworker was IPS Caseworker was IPS Caseworker was IPS Caseworker stated, IPS Caseworker was IPS |                    | 224     |   |  |                            |
|                          | by:   | is not met as evidenced R00018476) substantiated, findings:  |                    |         |   |  |                            |
|                          |   | n, record review and railed to fully operationalize rocedures related to the   |                    |         |   |  |                            |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X |  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   |                     |  |                                | (X3) DATE SURVEY<br>COMPLETED |  |
|--|--|--|---------------------|--|--------------------------------|-------------------------------|--|
|  |  | 045189   | B. WING _           |  | 0                              | C<br><b>7/27/2015</b>         |  |
|  | ROVIDER OR SUPPLIER  | IABILITATION, LLC  |                     | STREET ADDRESS, CITY, STATE, ZIP CO<br>900 MAGNOLIA RD<br>CAMDEN, AR 71701   |                                | 772772010                     |  |
| (X4) ID<br>PREFIX<br>TAG                             | (EACH DEFICI   | Y STATEMENT OF DEFICIENCIES<br>ENCY MUST BE PRECEDED BY FULL<br>OR LSC IDENTIFYING INFORMATION)  | ID<br>PREFII<br>TAG | PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE CROSS-REF | ON SHOULD BE<br>HE APPROPRIATE | (X5)<br>COMPLETION<br>DATE    |  |
| F 224  | as evidenced by to adequate pre-screplacement prior to factors due to be interventions pronounterventions provided to the content of the past 6 months and the provided the survey the Immediate Jec 5:15 p.m. The find 1. On 7/27/15 at 1 provided the Admid Alzheimer Care U documented as for the past 6 months and 1 provided the Admid Alzheimer Care U documented as for the past 6 months and 1 provided the Admid Alzheimer Care U documented as for the past 6 months and 1 provided the Admid Alzheimer Care U documented as for the past 6 months and 1 provided the Admid Alzheimer Care U documented as for the past 6 months and 1 provided the Admid Alzheimer Care U documented as for the past 6 months and 1 provided the Admid Alzheimer Care U documented as for the past 6 months and 1 provided the Admid Alzheimer Care U documented as for the past 6 months and 1 provided the Admid Alzheimer Care U documented as for the past 6 months and 1 provided the Admid Alzheimer Care U documented as for the past 6 months and 1 provided the Admid Alzheimer Care U documented as for the past 6 months and 1 provided the Admid Alzheimer Care U documented as for the past 6 months and 1 provided the Admid Alzheimer Care U documented as for the past 6 months and 1 provided the Admid Alzheimer Care U documented as for the past 6 months and 1 provided the Admid Alzheimer Care U documented as for the past 6 months and 1 provided the Admid Alzheimer Care U documented as for the pas | r Care Unit to prevent neglect the facilities failures to ensure pening for appropriateness of admission, to ensure risk naviors were identified with aptly developed and consistently assessed for effectiveness; to Adult Protective Services and, and facility management ping interventions to ensure as well as the other residents contact; to ensure sufficient resident to prevent resident ent #7) of 4 (Resident #7, #12, as mix residents who were pertified Alzheimer Care Unit in and ywhich caused or could have furly, harm or possible death for sustained an orbital and and had the potential to affect resided on the Certified as of 7/21/15. The Immediate proved by the facility on 7/21/15 the scope/severity reduced to "lity identified the issue and action however the facility did derlying deficient practice at the action however the facility did derlying deficient practice at the action however the facility did derlying deficient practice at the action however the facility did derlying deficient practice at the action however on 7/24/15 at lings are:  1:30 a.m., the Administrator assion/Discharge Criteria for the nit. The criteria was allows: | F2                  | 224  |                                |                               |  |

|                          |  | (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTI IDENTIFICATION NUMBER: A. BUILDIN   |                     | E CONSTRUCTION   | (X3) DATE SURVEY COMPLETED |  |
|--------------------------|--|--|---------------------|--|----------------------------|--|
|                          |  | 045189   | B. WING             |  | C<br>07/27/2015            |  |
|                          | ROVIDER OR SUPPLIER  S HEALTH AND REHA   | ABILITATION, LLC   | ,                   | STREET ADDRESS, CITY, STATE, ZIP CODE<br>200 MAGNOLIA RD<br>CAMDEN, AR 71701                             | 1 01/21/2010               |  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIE)   | STATEMENT OF DEFICIENCIES<br>NCY MUST BE PRECEDED BY FULL<br>R LSC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY) | BE COMPLETION              |  |
| F 224                    | injury, mental illnes (Persons with traun illness and mental in needs). Look for agrowing former lifestyle.  III. The resident mu (self-injurious) or of certify that (Facility Care Unit capacity recognized in comp. Term Care's rules a Special Care Units or otherwise hold it specialized unit for or related dementia.  2. The Department Human Services Roof Alzheimer's Special Care Handle Care Facility that separate and distin Care Facility that sepecial program for probable Alzheimer Dementia and that itself out as having | ess is not a result of head s or mental retardation. In the properties of the properties of the residents "This is to hame) Alzheimer Special is 40 beds is hereby oliance with the Office of Long and regulation for Alzheimer's and is authorized to advertise self out as offering a the residents with Alzheimer's and is authorized to advertise self out as offering a the residents with Alzheimer's and is authorized to advertise self out as offering a the residents with Alzheimer's and is authorized to advertise self out as offering a the residents with Alzheimer's are guilation Memo-Promulgation could care Unit Regulation for cumented, "The Office of s promulgated regulations for I Care Units (ASCU'S) For the regulations became, 2003. A copy of the need to this memorandum.  Simer's Special Care Unit. A cumit within a Long Term agregates and provides a residents with a diagnosis of the Disease or related advertises or otherwise hold one (1) or more special units | F 224               |  |                            |  |
|                          | for residents with d   | iagnosis of probable<br>e or related Dementia.   |                     |  |                            |  |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING  A. BUILDING |  |  | (X3) DATE SURVEY<br>COMPLETED |   |          |                            |
|---|--|--|-------------------------------|---|----------|----------------------------|
|   |  | 045189   | B. WING _                     |   |          | C<br>07/27/2015            |
|   | ROVIDER OR SUPPLIER  | BILITATION, LLC  |                               | STREET ADDRESS, CITY, STATE, ZIP CODE 900 MAGNOLIA RD CAMDEN, AR 71701                            |          | 0112112013                 |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIEN   | STATEMENT OF DEFICIENCIES<br>ICY MUST BE PRECEDED BY FULL<br>R LSC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG           | PROVIDER'S PLAN OF CORF<br>(EACH CORRECTIVE ACTION S<br>CROSS-REFERENCED TO THE AF<br>DEFICIENCY) | HOULD BE | (X5)<br>COMPLETION<br>DATE |
| F 224   | employee of the fact temporary agency a and who has receive accordance with this training regarding A Dementia and is reshands-on care or season.  3. The ACU [Alzheir containing policies, documentation for the was received from the Director (ACUD) on ACUD was asked if procedures that were unit was approved to Services as an according. The ACUD stated the approximately 3 were training. The ACUD was their advertising. The Policy and Procedures that were advertising to the initial assessment process with the inquiry and the initial assessment process of Alzheim other accompanying cause of increased rigorously evaluated social needs, prefer | ility or who is an employee of assigned to work in the facility ed or will receive in a regulation specialized; Izheimer's or related sponsible for providing direct, ervices to resident in the emer Care Unit] Book procedures, and other the specialized Alzheimer unit the Alzheimer Care Unit 7/25/15 at 5:55 p.m. The this was the policy and the put in place when the ACU by Department of Human edited Alzheimer's Care Unit extra she was hired the sago and was still in stated, "The Beacon book g, but also had policies."  Dedures were reviewed for the poumented "2. The seedures were reviewed for the pre-admission screening 9. The sent for ssion should Ascertain the | F 2                           | 24  |          |                            |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |  | (X2) MULTIPLE CONSTRUCTION  A. BUILDING   |                     |                                       | (X3) DATE SURVEY<br>COMPLETED   |        |                            |
|---|--|---|---------------------|---------------------------------------|---|--------|----------------------------|
|   |  | 045189  | B. WING             | B. WING                               |   |        | C<br>// <b>27/2015</b>     |
|   | ROVIDER OR SUPPLIER S HEALTH AND REHA  | BILITATION, LLC   |                     | STREET ADDRES 900 MAGNOLIA CAMDEN, AR |   | 1 07   | 12112013                   |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIEN   | STATEMENT OF DEFICIENCIES<br>CY MUST BE PRECEDED BY FULL<br>R LSC IDENTIFYING INFORMATION)  | ID<br>PREFII<br>TAG | (EA                                   | PROVIDER'S PLAN OF CORREC'<br>ACH CORRECTIVE ACTION SHOU<br>SS-REFERENCED TO THE APPRI<br>DEFICIENCY) | JLD BE | (X5)<br>COMPLETION<br>DATE |
| F 224   | participants in the p The Policy and Proc Care Unit book dood Department Dedical Subject: Staffing Po be sufficient consist dedicated to carry of the care plan of the "Department Heads retain accountability documenting the de as well as clinical of resource to the unit. nutritional, medical, needs when a resid change or evidence through unit staff int oversight on the unit Resident with cogni- more constant staff implementation of the each resident in the assignments are the aide system in whic Assistant] leads his through successful and recreation. Eac staff to resident ratio Staffing Ratio load should not exce Day/shift staffing rat Alzheimer's Care Si Evening Shift staffin | resonalities among the existing rogram."  redures in the Alzheimer's umented, ted Alzheimer's Care Unit licy documented, "There will ent and qualified staff ut the mission policies and dementia care services."  All facility department heads for assessing planning and livery of services on the unit versight including, acting as a Evaluating referral regarding social, and recreational ent experiences a significant is a need that cannot be met ervention. Provide clinical the structured daily plan for it assignment. Consistent is basis of the primary care in CNA [Certified Nursing there assigned residents activities of daily living, meals in unit will have established on | F2                  | 24                                    |   |        |                            |

|   |  | (X2) MULTIPLE CONSTRUCTION  A. BUILDING  |  |   | (X3) DATE SURVEY<br>COMPLETED  |  |
|---|--|--|--|---|--------------------------------|--|
|   | 045189   | B. WING _  |  | _   | 07/                            | 27/2015  |
|   | BILITATION, LLC  |  | STREET ADDRESS, CITY, STA<br>900 MAGNOLIA RD<br>CAMDEN, AR 71701   | ATE, ZIP CODE   | 1 0777                         | 27/2013  |
| (EACH DEFICIENC   | CY MUST BE PRECEDED BY FULL  | ID<br>PREFII<br>TAG  | (EACH CORREC<br>CROSS-REFEREN  | CTIVE ACTION SHOULD B<br>NCED TO THE APPROPRIA  |                                | (X5)<br>COMPLETION<br>DATE   |
| to 10 residents."  4. The Beacon Place Criteria received from Director (ACUD) on Skilled Nursing Facili Memory Care model services to meet the diagnosis of demention of the diagnosis of | e Program Binder Admission in the Alzheimer Care Unit 7/23/15 documented, "Policy ities that have a secure or will provide specialized needs of individuals with a.  Dementia. e environment viors  Illuate incoming residents to nilar or the same as outlined ze the following admission the current admissions ine if the resident is community. If a prospective cosis other that listed below, cosition will contact the inger for approval prior to  (included but not limited to) Type mentia  Dementia ary to brain injury.  eria: inger individuals will be   | F2   | 224  |   |                                |  |
|   |  |  |  |   |                                |  |
|   | ROVIDER OR SUPPLIER  SHEALTH AND REHAE  SUMMARY ST (EACH DEFICIENC REGULATORY OR  Continued From pag to 10 residents."  4. The Beacon Place Criteria received from Director (ACUD) on T Skilled Nursing Facili Memory Care model services to meet the diagnosis of dementi 65 years of age moderate to severe I Benefit from a secure with or without behave  Procedure Clinical team will evay verify a diagnosis sin below. Team will utilic criteria in addition to guidelines to determi appropriate for the cor resident has a diagnor the DON or similar pr Regional Clinical Ma admission.  Admitting Diagnosis Dementia Alzheimer Frontal Temporal Der Vascular Dementia Parkinson's related I Lewy Body Dementia Dementia's secondar  Basic Admission Crit 65 and younger (you considered on a case | ROVIDER OR SUPPLIER  S HEALTH AND REHABILITATION, LLC  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 29 to 10 residents."  4. The Beacon Place Program Binder Admission Criteria received from the Alzheimer Care Unit Director (ACUD) on 7/23/15 documented, "Policy Skilled Nursing Facilities that have a secure or Memory Care model will provide specialized services to meet the needs of individuals with diagnosis of dementia.  65 years of age moderate to severe Dementia. Benefit from a secure environment with or without behaviors  Procedure Clinical team will evaluate incoming residents to verify a diagnosis similar or the same as outlined below. Team will utilize the following admission criteria in addition to the current admissions guidelines to determine if the resident is appropriate for the community. If a prospective resident has a diagnosis other that listed below, the DON or similar position will contact the Regional Clinical Manger for approval prior to admission.  Admitting Diagnosis (included but not limited to) Dementia Alzheimer Type Frontal Temporal Dementia | A BUILDIE  O45189  ROVIDER OR SUPPLIER  S HEALTH AND REHABILITATION, LLC  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 29  to 10 residents."  4. The Beacon Place Program Binder Admission Criteria received from the Alzheimer Care Unit Director (ACUD) on 7/23/15 documented, "Policy Skilled Nursing Facilities that have a secure or Memory Care model will provide specialized services to meet the needs of individuals with diagnosis of dementia.  65 years of age moderate to severe Dementia. Benefit from a secure environment with or without behaviors  Procedure  Clinical team will evaluate incoming residents to verify a diagnosis similar or the same as outlined below. Team will utilize the following admission criteria in addition to the current admissions guidelines to determine if the resident is appropriate for the community. If a prospective resident has a diagnosis other that listed below, the DON or similar position will contact the Regional Clinical Manger for approval prior to admission.  Admitting Diagnosis (included but not limited to) Dementia Alzheimer Type Frontal Temporal Dementia Vascular Dementia Parkinson's related Dementia Lewy Body Dementia Dementia's secondary to brain injury.  Basic Admission Criteria: 65 and younger (younger individuals will be considered on a case by case basis) | ROWIDER OR SUPPLIER  S HEALTH AND REHABILITATION, LLC  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  COntinued From page 29  to 10 residents."  4. The Beacon Place Program Binder Admission Criteria received from the Alzheimer Care Unit Director (ACUD) on 7/23/15 documented, "Policy Skilled Nursing Facilities that have a secure or Memory Care model will provide specialized services to meet the needs of individuals with diagnosis of dementia.  65 years of age moderate to severe Dementia. Benefit from a secure environment with or without behaviors  Procedure  Clinical team will evaluate incoming residents to verify a diagnosis similar or the same as outlined below. Team will utilize the following admission criteria in addition to the current admissions guidelines to determine if the resident is appropriate for the community, if a prospective resident has a diagnosis other that listed below, the DON or similar position will contact the Regional Clinical Manger for approval prior to admission.  Admitting Diagnosis (included but not limited to) Dementia Alzheimer Type Frontal Temporal Dementia Vascular Dementia Lewy Body Dementia  Lewy Body Dementia  Dementia's secondary to brain injury.  Basic Admission Criteria: 65 and younger (younger individuals will be considered on a case by case basis) | A BUILDING    045189   B. WING | ONDITION OF THE PROPRIATE OF STREET ADDRESS, CITY, STATE, ZIP CODE  900 MAGNOLIA RD  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MISS TE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  COntinued From page 29 to 10 residents.*  4. The Beacon Place Program Binder Admission Criteria received from the Alzheimer Care Unit Director (ACUD) on 7/23/15 documented, "Policy Skilled Nursing Facilities that have a secure or Memory Care model will provide specialized services to meet the needs of individuals with diagnosis of dementia.  Benefit from a secure environment with or without behaviors  Procedure Clinical team will evaluate incoming residents to verify a diagnosis similar or the same as outlined below. Team will utilize the following admission criteria in addition to the current admissions guidelines to determine if the resident is appropriate for the community. If a prospective resident has a diagnosis other that listed below, the DON or similar position will contact the Regional Clinical Manger for approval prior to admission.  Admitting Diagnosis (included but not limited to) Dementia Alzheimer Type Frontal Temporal Dementia Parkinson's related Dementia Parkinson's related Dementia Parkinson's related Dementia Parkinson's related Dementia Dementia's secondary to brain injury.  Basic Admission Criteria: 65 and younger (younger individuals will be considered on a case by case basis) |

|                          |  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   | (X2) MULTIPLE CONSTRUCTION  A. BUILDING |  |   | (X3) DATE SURVEY<br>COMPLETED |                            |
|--------------------------|--|--|---|--|---|-------------------------------|----------------------------|
|                          |  | 045189   | B. WING _                               |  |   |                               | 27/ <b>2015</b>            |
|                          | ROVIDER OR SUPPLIER S HEALTH AND REHAB   | ILITATION, LLC   |   | STREET ADDRESS, CITY,<br>900 MAGNOLIA RD<br>CAMDEN, AR 71701 | , STATE, ZIP CODE   | 1 011                         | 2772013                    |
| (X4) ID<br>PREFIX<br>TAG | PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL   |  | ID<br>PREFIX<br>TAG                     | (EACH COR  | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) |                               | (X5)<br>COMPLETION<br>DATE |
| F 224                    | Continued From page  | e 30   | f 2                                     | 24   |   |                               |                            |
|                          |  | current community setting herapeutic environment."   |   |  |   |                               |                            |
|                          | 4/6/15 with diagnose   | dmitted to the facility on s of Dementia with ce, Schizophrenia, Anxiety   |   |  |   |                               |                            |
|                          | "Admit Date: 03/13 a psych unit in Little I and /or taking food for Concern was express on an acute unit and facility, he has been absolutely unavailable time" The Dischadocumented, "Princibehavioral disturband Schizophrenia. The Patient arrived as and due to confusion and as well as a tendency clients at that Psychiafelt he was at risk for clients at that facility Hospital Course: Pat and continued to evic intrusiveness, and eatendency to not take promptingDespite i the patient remained intrusive and difficult | 3/13/15 documented, /2015He apparently was in Rock and he was aggressive om other people's trays? sed that he might be harmed was sent to Geri unit. At this noted to lay on other people lothing. Any other history is e to this physician at this rge Summary dated 4/6/15 ple Diagnosis: Dementia with ces Secondary Diagnoses Reason for Hospitalization: eferral from (Hospital Name) inability to care for himself y to be so intrusive with other atric facility that staff there being beaten as most of the were younger than the client. ient was admitted to our unit |   |  |   |                               |                            |
|                          | terms of side effects.  The Quarterly Minimum  | "<br>um Data Set (MDS) with  |   |  |   |                               |                            |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING  |  |  | (X3) DATE SURVEY COMPLETED C |   |           |                            |
|---|--|--|------------------------------|---|-----------|----------------------------|
|   |  | 045189   | B. WING                      |   |           | 07/27/2015                 |
| NAME OF PROVIDER OF   |  | ABILITATION, LLC   |                              | STREET ADDRESS, CITY, STATE, ZIP CODI<br>900 MAGNOLIA RD<br>CAMDEN, AR 71701                |           | <u> </u>                   |
|   | ACH DEFICIE  | STATEMENT OF DEFICIENCIES<br>NCY MUST BE PRECEDED BY FULL<br>R LSC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG          | PROVIDER'S PLAN OF COI<br>(EACH CORRECTIVE ACTION<br>CROSS-REFERENCED TO THE<br>DEFICIENCY) | SHOULD BE | (X5)<br>COMPLETION<br>DATE |
| Assessar docume indicate: for Ment had war required mobility, and persincontinion was 75 received Antianxi respons Service)  a. Depa docume admitted Unit LTC indepen gait."  b. Depa days) do of increasintrusive Departm consultar manage being in behaviors. Find dist | nted the resistant of the severely is all Status (Budering behalimited assistants fers, sonal hygies and of bower sonal hygies and of the set o | ence Date (ARD) 7/13/15 sident scored 3 (a score of 0-7 mpaired) on the Brief Interview BIMS); had a mood score of 0; aviors that occurred daily; sistance of 1 person for bed ambulation in room or corridor ne; was occasionally el and bladder; had no pain; bot 2 1/2 inches) in height; and otic, Antidepressant and tion 7 of the past 7 days. The vas APS (Adult Protective | F 22                         |   |           |                            |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |   | (X2) MULT<br>A. BUILDIN   | IPLE CONSTRUCTION  NG |  | (X3) DATE SURVEY<br>COMPLETED |                            |
|---|---|---|-----------------------|--|-------------------------------|----------------------------|
|   |   | 045189  | B. WING _             |  |                               | C<br>07/27/2015            |
|   | ROVIDER OR SUPPLIER   | BILITATION, LLC   |                       | STREET ADDRESS, CITY, STATE, ZIP CODE<br>900 MAGNOLIA RD<br>CAMDEN, AR 71701               |                               | 0172172010                 |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIEN  | STATEMENT OF DEFICIENCIES<br>CY MUST BE PRECEDED BY FULL<br>R LSC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG   | PROVIDER'S PLAN OF CORE ( (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY) | HOULD BE                      | (X5)<br>COMPLETION<br>DATE |
| F 224   | documented, "On 4. is becoming verbally other residents. He else I will hold you i will be put in jail for points at a female redon't say a word or medicated with Hald awake wandering a soda from a female it down and he uses 3) Departmental No a.m. documented, "resident is up wand and telling female re say anything. Attemseat and he states resident wander wit seated himself at ta IM right deltoid."  Departmental Notes documented, " New [Physician] derease mg at hs [hour of sle Zyprexa, give Seroc 50 mg at hs APS notified" | tes dated 4/9/15 at 2:17 a.m.  18/15 at 3:00 p.mResident 1/ aggressive with staff and 1/ states, 'If you say anything 1/ contempt of court and you 1/ no less than 9 days.' He 1/ resident states 'Sit down and 1/ will put you in jail.' Resident 1/ resident states 'Sit down and 1/ will put you in jail.' Resident 1/ resident states aresident she asks him to put 1/ resident she asks him to put 1/ resident she asks him to put 1/ resident to sit down and do not 1/ resident to his 1/ resident to his 1/ resident to his 1/ resident to his 1/ resident to put 1/ resident to his 1/ resident to put 1/ resident to his 1/ resident to put 1/ resident to put 1/ resident to put 1/ resident seated in her 1/ resident seated in her | F2                    | 224  |                               |                            |
|   | 50 mg at hs APS notified"  4) Departmental No documented, "On 4, went to stand over f w/c [wheelchair] and my chair' resident of  | E [Adult Protective Services] tes dated 4/11/15 at 1:01 a.m. 10/15 at 4:45 p.m. Resident  |                       |  |                               |                            |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING |  |  | (X3) DATE SURVEY<br>COMPLETED |         |   |                 |                            |
|--|--|--|-------------------------------|---------|---|-----------------|----------------------------|
|  |  | 045189   | B. WING                       | B. WING |   | C<br>07/27/2015 |                            |
| NAME OF P  | ROVIDER OR SUPPLIER  | 0.000  | 1                             | ç       | STREET ADDRESS, CITY, STATE, ZIP CODE   | <u> </u>        | 2//2015                    |
|  | S HEALTH AND REHAB   | ILITATION, LLC   |                               | 9       | 000 MAGNOLIA RD<br>CAMDEN, AR 71701   |                 |                            |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIENC)   | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)   | ID<br>PREFI<br>TAG            |         | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) |                 | (X5)<br>COMPLETION<br>DATE |
| F 224  | resident daughter and redirects across the h IM for increased agitata p.m. Resident is in a seleave room. He was minutes spent with resulting to the p.m. at 7:30 p.m. door pushed the west exit causing the alarm to sHaldol 5 mg IM."  6) Departmental Note p.m. documented, "Reverbally abusive to readministered Lorazer 2130 [9"30 p.m.]"  7) Departmental Note p.m. documented, "Reverbally abusive to readministered Lorazer 2130 [9"30 p.m.]"  7) Departmental Note p.m. documented, "Reverbally abusive to readministered Lorazer 2130 [9"30 p.m.]"  7) Departmental Note p.m. documented, "Resident got hold of h started pushing it down attempted to get cart became combative, had better get away from cart continuother resident belong agitated and verbally 1200 Lorazepam 1 m much difficulty."  8) Departmental Note documented, "4/22/18 turned to water on in placed a trash can in | d states, "You are a lie." Staff call for privacy Haldol 5 mg stion/aggressiveness. 7:30 female room and refuses to redirected by staff after 15 direction"  It states 4/13/15 at 10:28 sumented, "resident door open to the courtyard sound. Resident redirected  It states 4/19/15 at 10:44 esident up pacing hallway sidents and staff.  It states and staff.  It states a dated 4/20/15 at 12:39 the sident observed pacing in sident's rooms picking up utting them in his pocket. In housekeepers cart and when the hallway staff x 3 away from him and he sitting at staff and saying we room him. Eventually walked ue to pick up and pocket | F                             | 224     |   |                 |                            |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: |  | (X2) MULT<br>A. BUILDIN   | IPLE CONSTRUCTION  NG |   | (X3) DATE SURVEY<br>COMPLETED |                            |
|--|--|---|-----------------------|---|-------------------------------|----------------------------|
|  |  | 045189  | B. WING _             |   |                               | C<br>07/27/2015            |
|  | ROVIDER OR SUPPLIER  S HEALTH AND REHA   | BILITATION, LLC   |                       | STREET ADDRESS, CITY, STATE, ZIP CODE 900 MAGNOLIA RD CAMDEN, AR 71701                      |                               | 0112112013                 |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIEN   | STATEMENT OF DEFICIENCIES<br>CY MUST BE PRECEDED BY FULL<br>R LSC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG   | PROVIDER'S PLAN OF COI<br>(EACH CORRECTIVE ACTION<br>CROSS-REFERENCED TO THE<br>DEFICIENCY) | I SHOULD BE                   | (X5)<br>COMPLETION<br>DATE |
| F 224  | Continued From page  | ge 34   | F 2                   | 224   |                               |                            |
|  | corridor. He is wan-<br>room removing their<br>other itemshe the<br>mealHe refused to  | which then flowed out into the dering into other residents walkers, trash cans, and en was served alternate beat became verbally f. He was medicated with the deltoid."   |                       |   |                               |                            |
|  | documented, "Resid<br>door this morning, a<br>when staff attempte<br>[Physician] notified,<br>Lorazepam 1 mg po<br>[hours] prn agitation | dated 4/23/15 at 2:54 p.m. dent followed staff out of exit gitated and slightly combative d to redirect him back new order received for [by mouth] q [every] 4 hrs" Departmental Notes at ted the physician would be at and make medication |                       |   |                               |                            |
|  | at 11:00 a.m. docun<br>agitated and started<br>eye wash station. H<br>knocking out a pane  | tes dated 4/26/15 at 1:39 p.m. nented, "Resident became to ambulate in hallway by it window with his right hand of plexi-glass. No injury. with Lorazepam 1 mg IM r ion."   |                       |   |                               |                            |
|  | p.m. documented, "<br>pacing the hallway I<br>[agitation] noted to I<br>refuses to go into di  | otes dated 4/29/15 at 12:37 12:34 p.m. R [Resident] back and forth. Agitstion be increased at this time. R ning room and eat, stating ' in there.' Lorazepam 1 mg   |                       |   |                               |                            |
|  | a.m. documented, 1 back and forth in ha  | otes dated 4/30/15 at 2:18<br>:00 a.m. Resident up pacing<br>Ilways not easily redirected<br>then redirecting resident.   |                       |   |                               |                            |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |   | 1 ' '   | E CONSTRUCTION      | (X3) DATE SURVEY<br>COMPLETED  |                 |  |
|---|---|---|---------------------|--|-----------------|--|
|   |   | 045189  | B. WING             |  | C<br>07/27/2015 |  |
|   | ROVIDER OR SUPPLIER   | BILITATION, LLC   | g                   | STREET ADDRESS, CITY, STATE, ZIP CODE<br>100 MAGNOLIA RD<br>CAMDEN, AR 71701                               | 1 0112112010    |  |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIEN  | STATEMENT OF DEFICIENCIES<br>NCY MUST BE PRECEDED BY FULL<br>R LSC IDENTIFYING INFORMATION) | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY) | BE COMPLETION   |  |
| F 224   | ml (1 mg) IM given  c. Departmental No Medication Adminis 5/1/15 - 5/31/15 (31 resident had 24 epi aggression, and/or PRN medication. The document consultate facility management risk of being injured behaviors  1) Departmental No documented, "At 1 back and forth in ha and trying to hit star mg administered. A pacing back and for [angry] balling fist a residents. Lorazepa  2) Departmental No documented, "at a pacing back and for [angry], balling fist a residents. Lorazepa  3) The back of the I the resident was ac p.o. for increased at  4) The back of the I the resident was ac p.o. for increased at | 2 mg/ml carpuject inject 0.5  | F 224               |  |                 |  |
|   | 1 -   | otes dated 5/6/15 at 3:54 a.m. p.m. Resident up wandering                                   |                     |  |                 |  |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: |  | (X2) MULTIPLE<br>A. BUILDING _   | CONSTRUCTION        | (X3) DATE SURVEY COMPLETED  |                        |  |
|--|--|--|---------------------|---|------------------------|--|
|  |  | 045189   | B. WING             |   | C<br><b>07/27/2015</b> |  |
|  | ROVIDER OR SUPPLIER  | BILITATION, LLC  | 9                   | STREET ADDRESS, CITY, STATE, ZIP CODE  900 MAGNOLIA RD  CAMDEN, AR 71701                                |                        |  |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIEN   | STATEMENT OF DEFICIENCIES<br>ICY MUST BE PRECEDED BY FULL<br>R LSC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY) | ) BE COMPLETION        |  |
| F 224  | Continued From pa  | ge 36  | F 224               |   |                        |  |
|  | hallways not easily<br>Ativan 1 mg 1 tab p   | redirected easily agitated.<br>o given"  |                     |   |                        |  |
|  | documented, "5:30 attempting to wand   | ates dated 5/7/15 at 6:28 a.m.<br>a.m. Resident is up<br>er throughout halls. Not easily<br>sed agitation Ativan 1 mg po   |                     |   |                        |  |
|  | documented, "0915<br>agitation at this time<br>not leave things on<br>noted trying to mov<br>another R was lean<br>noncompliant with r | tes dated 5/7/15 at 1:02 p.m. R is noted to have extreme B. Housekeeper state he will her cart alone. R [Resident] the the doghouse on the unit as ing on it as he does daily. R the direction. Lorazepam 2 the toto 1.5 ml (1 mg) IM given at the control of the con |                     |   |                        |  |
|  | "1100-R is noted ac<br>another R room with<br>other residents bath   | s dated 5/7/15 at 1:16 p.m.,<br>cross the hall from his room in<br>nout pants or brief on. R in<br>nroom running the water to the<br>flowing. R taken back to his  |                     |   |                        |  |
|  | documented, "Resid<br>down hallways. Inat<br>knobs trying to open<br>house trying to pick  | otes dated 5/8/15 at 12:08 a.m. dent up wandering up and tention fidgeting with door in doors. Moving the dog it up. Not easily redirected in Ativan 1 mg 1 tablet given   |                     |   |                        |  |
|  | documented, "Resident of getting into drawers counter. Resident of the second counter."  | tes dated 5/8/15 at 6:02 a.m.<br>dent wandering in dining room<br>and anything that is on the<br>vill not put on clothing and not<br>his room. Increased agitation   |                     |   |                        |  |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION  A. BUILDING  A. BUILDING |   | COM  | COMPLETED           |   |         |                            |
|--|---|--|---------------------|---|---------|----------------------------|
|  |   | 045189   | B. WING             |   |         | C<br>/ <b>27/2015</b>      |
|  | ROVIDER OR SUPPLIER   |  |                     | STREET ADDRESS, CITY, STATE, ZIP CODE 900 MAGNOLIA RD CAMDEN, AR 71701                                  | 1 07    | 12112013                   |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIEN  | TATEMENT OF DEFICIENCIES<br>CY MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORREC<br>(EACH CORRECTIVE ACTION SHO<br>CROSS-REFERENCED TO THE APPF<br>DEFICIENCY) | OULD BE | (X5)<br>COMPLETION<br>DATE |
| F 224  | 1 tab po given"  10) Departmental Nat 11:59 a.m. docum of resident's rooms of turning water on not noted to be incontine approached him for very resistive and be Male staff arrived ar 12:30 Ativan 1 mg p  11) The back of the the resident was add p.o. for increased accommended, "11:30 wandering halls with pants. Not easily recommended, "Resident and on in room. If the documented, "Resident and on in room. If over room. Has diap wrong way. Resident easily redirected. At 14) The back of the the resident was add p.o. for increased accommended accommen | oftes Addendum dated 5/8/15 lented, "Resident in and out going in bathrooms and easily redirected. Resident ent of bowel, when staff toileting and peri-care he's ecame slightly combative. Id peri-care given per 3 staff. Io given"  May 2015 MAR documented ministered Lorazepam 1 mg gitation at 7:00 p.m. on 5/8/15.  Intest dated 5/8/15 at 4:44 a.m. Ip.m.] Resident up diaper on head and no directed increase in agitation esident go back to room. Intest dated 5/9/15 at 6:05 a.m. Intest greatent as [has] clothing all er on head and shirt on t urinating outside door. Not van 1 mg po given"  May 2015 MAR documented ministered Lorazepam 1 mg gitation at 7:00 p.m. on | F 23                | 24  |         |                            |
|  |   | n. Resident is up wandering<br>the dining room, turning on   |                     |   |         |                            |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: |  | (X2) MULTI<br>A. BUILDIN  | PLE CONSTRUCTION  G |   | (X3) DATE SURVEY COMPLETED |                            |
|--|--|---|---------------------|---|----------------------------|----------------------------|
|  |  | 045189  | B. WING _           |   |                            | C<br><b>07/27/2015</b>     |
|  | ROVIDER OR SUPPLIER  | ABILITATION, LLC  |                     | STREET ADDRESS, CITY, STATE, ZIP CODE 900 MAGNOLIA RD CAMDEN, AR 71701                          |                            | 01/21/2013                 |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIEI   | STATEMENT OF DEFICIENCIES<br>NCY MUST BE PRECEDED BY FULL<br>R LSC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF COR<br>(EACH CORRECTIVE ACTION S<br>CROSS-REFERENCED TO THE A<br>DEFICIENCY) | SHOULD BE                  | (X5)<br>COMPLETION<br>DATE |
| F 224  | Continued From pa  | ge 38   | F 2                 | 24  |                            |                            |
|  | and other residents and food but contin He is medicated wi 16) The back of the the resident was ac p.o. for increased a (7:40 p. m.).  | k, becoming loud with staff b. He is redirected with fluids ues with behavior escalation. Ith Ativan 1 mg 2 po"  May 2015 MAR documented Iministered Lorazepam 1 mg Ingitation on 5/16/15 at 1940  May 2015 MAR documented Iministered Lorazepam 1 mg Ingitation on 5/17/15 at 1610   |                     |   |                            |                            |
|  | p.m. documented, observed standing out at parking lot, hand needs to go ge window, multiple at away from window became severely a aggressive. At 10:3 Lorazepam 0.5 ml resident became exand unable to give 1 mg po given and 19) Departmental Np.m. documented, with Ativan 1 mg 1 when staff attempts clothes. " | Notes dated 5/21/15 at 4:04 "1000 [10 a.m.] Resident at window in kitchen looking e said he see his car out there et it, he attempted to open tempts per staff to divert him before he complied, then he gitated with staff and verbally 10 a.m. attempted to give 1 mg IM per assist x 3 staff, ktremely agitated and resistive complete dose Lorazepam taken without incident"  Notes dated 5/21/15 at 11:42 '7:00 p.m. He is medicated po for increased agitation is to assist with changing of his  Notes dated 5/22/15 at 6:43 "1:10 a.m. gave bruse [?] |                     |   |                            |                            |
|  | 0.5mg im [IM]for be  | "1:10 a.m. gave bruse [?]<br>eing vety [very] aggitated<br>g to take things in other  |                     |   |                            |                            |

|                          | DEFICIENCIES<br>CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   | (X2) MULTIPLE CONSTRUCTION  A. BUILDING |  | (X3) DATE SURVEY COMPLETED |  |
|--------------------------|--|--|---|--|----------------------------|--|
|                          |  | 045189   | B. WING                                 |  | C<br>07/27/2015            |  |
|                          | ROVIDER OR SUPPLIER  | 1  |   | STREET ADDRESS, CITY, STATE, ZIP CODE 900 MAGNOLIA RD CAMDEN, AR 71701                                       | 0112112013                 |  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIEN   | TATEMENT OF DEFICIENCIES<br>CY MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG                     | PROVIDER'S PLAN OF CORRECTI<br>(EACH CORRECTIVE ACTION SHOUL<br>CROSS-REFERENCED TO THE APPRO<br>DEFICIENCY) | D BE COMPLETION            |  |
| F 224                    | documented Loraze administered.  21) Departmental No. a.m. documented, "/window in dining root trying to open it, not dining room and beg pounding on door ar Lorezepan 1 mg po  22) Departmental No. p.m. documented, "S resident has been poresidents rooms and became agitated with Lorezepam 1 mg po  23) Departmental No. p.m. documented, "S pacing in the corridor wandering in other resident #7] back in Director of Nurses of [Resident #7] back in Director of Nurses] of [room #33] concerns his room. At 7:00 p.r. into room #34 when agitated states, 'Ju gave resident sandwing medicated him with a gave resident sandwing medicated him with a look of the proof of Nurses of the pacing in the corridor of Nurses of the pacing in the corridor wandering in other resident sandwing and with resident sandwing an | al." The May 2015 ration Record (MAR) part 1 mg IM was obtes dated 5/22/15 at 11:18 1045 Resident observed at an pulling up on window and easily diverted. Resident left lan pacing in hallways and ad window of Nursing Station. given"  Ottes dated 5/25/15 at 1:46 Since out of bed this morning acing, going in other getting their belongings, he h staff when redirected. given at 11:30 a.m"  Ottes dated 5/25/15 at 11:35 S:40 p.m. Resident up and rs. He has behavior of esidents rooms. Resident in a doesn't want this resident in this room. ADON [Assistant was notified of the resident in the fof this resident coming into m. Resident has wandered redirecting him he became st leave me alone ', staff vich and sweet tea and Ativan 1 mg po. Staff remains dent [#7] until he agrees to go | F 22                                    | 24   |                            |  |
|                          | documented, "Resid   | dated 5/27/15 at 3:44 p.m.<br>dent pacing hallways and<br>dents rooms pilfering in   |   |  |                            |  |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION  A. BUILDING |  | COMPLETED   |                     |  |                 |
|---|--|---|---------------------|--|-----------------|
|   |  | 045189  | B. WING             |  | C<br>07/27/2015 |
|   | ROVIDER OR SUPPLIER  | BILITATION, LLC   | ,                   | STREET ADDRESS, CITY, STATE, ZIP CODE<br>900 MAGNOLIA RD<br>CAMDEN, AR 71701                               | 1 01/21/2010    |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIENC  | TATEMENT OF DEFICIENCIES<br>CY MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY) | BE COMPLETION   |
| F 224   | activities/food/fluids. increasingly agitated [Physician] with new Seroquel to 50 mg ir notified of new order  Departmental Notes documented, "[Phys resident with no new Physician Progress I documented, "HPI [Ir information]/Social H to psych facility for A aggressively taking for trays. Because of his felt that there might I being placed in acut admitted to the Geria been reported that hother peoples' beds Beyond that, I can't generated to the meetaking. At this point responds with the swind [twice daily]"  24) Departmental Not p.m. documented, "A Lorazepam 2 mg IM [agitation]." d. Departmental Not Medication Administ 6/1/15 - 6/30/15 (30 resident had 13 epis aggression, and/or in | Attempts to redirect with Resident becomes towards staff. Call placed to orders received to increase am and 100 mg hs. [APS] s"  dated 5/28/15 at 4:34 p.m. ician] here to examine orders received. "  Notes dated 5/28/15 iistory and physical listory:He was transferred aggressive behavior, it was be some issues with him a care unit, so he was atric Unit at this facility. It had be was found on occasion on removing their clothes. Get much elsePlan: He better with the dose dications he came in here we 'Il sit tight and see how he witch from Abilify to Seroquel of the staff of | F 224               |  |                 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING  A. BUILDING |  | COMPLETED   |                     |   |                        |
|---|--|---|---------------------|---|------------------------|
|   |  | 045189  | B. WING             |   | C<br><b>07/27/2015</b> |
|   | ROVIDER OR SUPPLIER  |   |                     | STREET ADDRESS, CITY, STATE, ZIP CODE 900 MAGNOLIA RD CAMDEN, AR 71701  | 0112112013             |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIENC  | TATEMENT OF DEFICIENCIES<br>CY MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROPE<br>DEFICIENCY) | BE COMPLETION          |
| F 224   | facility management risk of being injured behaviors:  1) Departmental Not documented, "At 143 in eyewash room, has meared it on cabinarefused to change his assist him, he becan threatening. Lorazer  2) The back of the Justine resident was adripo. for increased agram.  3) The back of the Justine resident was adriff for behavior on 6.  4) The back of the Justine resident was adriff for behavior agitarism.).  5) The back of the Justine resident was adripo. for increased agram.  6) The back of the Justine resident was adripo. for increased agram. | on with physician, APS, or regarding resident increased or injuring others due to his es dated 6/1/15 4:10 p.m. 80 [2:30 p.m.] Resident went ad BM [bowel movement] ets and is clothing. He s clothes or allow staff to the verbally and physically | F 22-               | 4   |                        |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: |  | (X2) MULT<br>A. BUILDIN   | IPLE CONSTRUCTION  NG | (X3)   | ) DATE SURVEY<br>COMPLETED |                            |
|--|--|---|-----------------------|--|----------------------------|----------------------------|
|  |  | 045189  | B. WING _             |  |                            | C<br><b>07/27/2015</b>     |
|  | ROVIDER OR SUPPLIER  | BILITATION, LLC   |                       | STREET ADDRESS, CITY, STATE, ZIP CODE 900 MAGNOLIA RD CAMDEN, AR 71701                             |                            | 0112112013                 |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIEN   | STATEMENT OF DEFICIENCIES<br>CY MUST BE PRECEDED BY FULL<br>R LSC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG   | PROVIDER'S PLAN OF CORI<br>( (EACH CORRECTIVE ACTION S<br>CROSS-REFERENCED TO THE A<br>DEFICIENCY) | SHOULD BE                  | (X5)<br>COMPLETION<br>DATE |
| F 224  | the resident was ad IM for behavior agita (10:02 p.m.).  9) The back of the 3 the resident was ad p.o. for increased aga.m.  10) The back of the the resident was ad p.o. for increased agp.m.  11) The back of the the resident was ad p.o. for increased agp.m.  11) The back of the the resident was ad p.o. for increased aga.m.  12) Departmental N documented, "4:20 pass staff he caugh around her left wrist resident to released dining room for food to be verbal aggress. | ge 42  June 2015 MAR documented ministered Lorazepam 1 mg ation on 6/21/15 at 2202  June 2015 MAR documented ministered Lorazepam 1 mg gitation on 6/23/15 at 10:45  June 2015 MAR documented ministered Lorazepam 1 mg gitation on 6/23/15 at 3:30  June 2015 MAR documented ministered Lorazepam 1 mg gitation on 6/23/15 at 3:30  June 2015 MAR documented ministered Lorazepam 1 mg gitation on 6/26/15 at 9:30  June 2015 MAR documented ministered Lorazepam 1 mg gitation on 6/26/15 at 9:30  June 2015 MAR documented ministered Lorazepam 1 mg gitation on 6/26/15 at 9:30  June 2015 MAR documented ministered Lorazepam 1 mg gitation on 6/26/15 at 9:30  June 2015 MAR documented ministered Lorazepam 1 mg gitation on 6/26/15 at 9:30 | F2                    | 224  |                            |                            |
|  | 13) The back of the the resident was ad  | June 2015 MAR documented ministered Lorazepam 1 mg gitation on 6/27/15 at 11:40   |                       |  |                            |                            |
|  | Medication Adminis   | tes and the July 2015<br>tration Record (MAR) from<br>days) documented the  |                       |  |                            |                            |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: |  | (X2) MULT<br>A. BUILDIN  | IPLE CONSTRUCTION  NG |  | (X3) DATE SURVEY COMPLETED |                            |
|---|--|--|-----------------------|--|----------------------------|----------------------------|
|   |  | 045189   | B. WING _             |  |                            | C<br>07/27/2015            |
|   | ROVIDER OR SUPPLIER  | BILITATION, LLC  |                       | STREET ADDRESS, CITY, STATE, ZIP CODE 900 MAGNOLIA RD CAMDEN, AR 71701                   | •                          | 0772772013                 |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIEN   | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG   | PROVIDER'S PLAN OF COR ( (EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY) | SHOULD BE                  | (X5)<br>COMPLETION<br>DATE |
| F 224   | Continued From pag   | ge 43  | F 2                   | 224  |                            |                            |
|   | aggression, and/or i<br>PRN medication. The<br>document consultation<br>facility management                            | odes of increased agitation, intrusiveness that required the Departmental Notes did not on with physician, APS, regarding resident increased or injuring others due to his |                       |  |                            |                            |
|   | the resident was ad  | uly 2015 MAR documented ministered Lorazepam 1 mg gitation on 7/01/15 at 3:00  |                       |  |                            |                            |
|   | documented, "10:30 resident observed o hallways, going in m bothering them. Resmanic like mode wit threatening towards | some staff. All attempts to vith activities snacks, 1-1  |                       |  |                            |                            |
|   | the resident was ad  | uly 2015 MAR documented<br>ministered Lorazepam 1 mg<br>gitation on 7/4/15 at 9:15 a.m.  |                       |  |                            |                            |
|   | the resident was ad  | uly 2015 MAR documented<br>ministered Lorazepam 1 mg<br>gitation on 7/5/15 at 9:00 a.m.  |                       |  |                            |                            |
|   | the resident was ad  | uly 2015 MAR documented<br>ministered Lorazepam 1 mg<br>gitation on 7/8/15 at 11:30  |                       |  |                            |                            |
|   | documented, "10:45   | tes dated 7/16/15 at 3:19 p.m.<br>a.m. Resident woke up this<br>mood, pacing with angry of   |                       |  |                            |                            |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: |  |  | TIPLE CONSTRUCTION  NG |  | DATE SURVEY<br>COMPLETED     |                            |
|--|--|--|------------------------|--|------------------------------|----------------------------|
|  |  | 045189   | B. WING_               |  |                              | C<br><b>07/27/2015</b>     |
|  | ROVIDER OR SUPPLIER S HEALTH AND REHAB   |  |                        | STREET ADDRESS, CITY, STATE, ZIP COD<br>900 MAGNOLIA RD<br>CAMDEN, AR 71701                | <u> </u>                     | 0//2//2015                 |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIENC  | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG    | PROVIDER'S PLAN OF CO<br>(EACH CORRECTIVE ACTION<br>CROSS-REFERENCED TO THE<br>DEFICIENCY) | N SHOULD BE<br>E APPROPRIATE | (X5)<br>COMPLETION<br>DATE |
| F 224  | Continued From page  | e 44   | F 2                    | 224  |                              |                            |
|  | tone of voice when st  | aff cues him for redirections<br>r breakfast. Resident made<br>t did not make contact.   |                        |  |                              |                            |
|  |  | nprehensive Care Plan with<br>5 cpoc (continue plan of   |                        |  |                              |                            |
|  | aggressive behaviors episodes of verbally a 50%. Approaches me and provide diver document my behaviorated 4/26/15 document on secured unit, with windows. Nursing sta  | 4/15 I display verbally c. GoalI will decrease my aggressive behaviors by Activities staff to visit with sion activities. Observe and ors " A handwritten note ented, "Broke window out no injuries. Secured  off in-serviced to administer d before behaviors becomes |                        |  |                              |                            |
|  | [and]/or Behavior corresponding processing p | Remove to a private s are disrupting to others" ated 4/10/15 documented, ggression towards [discontinue] Zyprexa 10 mg one 150 mg hs Seroquel 25 m"  |                        |  |                              |                            |
|  | being injured or injuri  | address resident's risk of<br>ng others due to his intrusive<br>viors. The care plan had no<br>er 4/26/15 for  |                        |  |                              |                            |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |   |  |                     |  | DATE SURVEY<br>COMPLETED |                            |
|---|---|--|---------------------|--|--------------------------|----------------------------|
|   |   | 045189   | B. WING             |  |                          | C<br><b>07/27/2015</b>     |
|   | ROVIDER OR SUPPLIER   |  |                     | STREET ADDRESS, CITY, STATE, ZIP CODE 900 MAGNOLIA RD CAMDEN, AR 71701                           | I                        | 07/27/2015                 |
| (X4) ID<br>PREFIX<br>TAG  | REFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL   |  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORI<br>(EACH CORRECTIVE ACTION S<br>CROSS-REFERENCED TO THE A<br>DEFICIENCY) | SHOULD BE                | (X5)<br>COMPLETION<br>DATE |
| F 224   | mood/behaviors.  g. Departmental Nota.m. documented, "on Nurse at Nurse's start attacked me.' this nurse at Nurse's start attacked me.' this nurse at Nurse's start attacked me.' this nurse separate of the start was a start attacked me.' this nurse separated of this resident for the face of this resident for the face of this nurse separated of this nurse separated of this nurse separated of this nurse separated on the face of this nurse separated of this nurse separated on the face of the face | des dated 7/21/15 at 7:30 a.m. Resident came to be | F 2                 | 24   |                          |                            |
|   | right eye was swoller   | of the facility, the resident's  n shut and there was be bruising, and bruising to the |                     |  |                          |                            |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |   | 1 ' '  | (X2) MULTIPLE CONSTRUCTION (X3)  A. BUILDING |   |           |                            |
|---|---|--|--|---|-----------|----------------------------|
|   |   | 045189   | B. WING                                      |   |           | C<br><b>07/27/2015</b>     |
|   | ROVIDER OR SUPPLIER S HEALTH AND REHAE  | 1 1 11   |  | STREET ADDRESS, CITY, STATE, ZIP CODE 900 MAGNOLIA RD CAMDEN, AR 71701                          | •         | 07/27/2015                 |
| (X4) ID<br>PREFIX<br>TAG  | FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL   |  | ID<br>PREFIX<br>TAG                          | PROVIDER'S PLAN OF COR<br>(EACH CORRECTIVE ACTION :<br>CROSS-REFERENCED TO THE A<br>DEFICIENCY) | SHOULD BE | (X5)<br>COMPLETION<br>DATE |
| F 224   | Continued From pag  | e 46   | F 2  | 24  |           |                            |
|   |   | e was dried blood on both<br>f bright red blood from the   |  |   |           |                            |
|   | and Accident Report<br>documented the type<br>taken to prevent con<br>during the investigati<br>initiated immediately<br>Enforcement and Ad<br>[Resident #7] was re<br>Nurse Station for eva<br>safety. First Aid was   | e of abuse Physical. Steps tinued Abuse or neglect on: "An investigation was . Family, Local Law ministrator were notified. moved from room taken to aluation and placed 1:1 for provided to Resident [#8] by N) #1 and [Resident #8] was asported to [hospital R)] for evaluation.  |  |   |           |                            |
|   | and signed Alzheime (ACUD) documented p.m. this Nurse took monitoring to relieve was ambulating up a went into the room o had difficulty redirect He was exhibiting stelingo" when speaking open the door he wa grabbed my wrist stathey will find you har redirected and back became increasingly He opened the door entered and I was ur the room. [Resident: shoe belonging to the | es dated 7/23/15 at 3:14 p.m.  r's Care Unit Director I, "At approximately 1:30 over the 1:1 continuous CNA for lunch. [Resident #7] nd down hallway. Resident If two female residents and I ing him to leave the room.  ernness and reverting to "cop to me. I attempted to hold s trying to shut and he ting. 'I will murder you and aging in the trees ' Once into hallway, resident agitated and inconsolable. to another resident's room, hable to redirect him out of #7] reached down to grab a te resident became verbally |  |   |           |                            |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |   | (X2) MULT<br>A. BUILDII  | TIPLE CONSTRUCTION  NG |   | ATE SURVEY<br>DMPLETED |                            |
|---|---|--|------------------------|---|------------------------|----------------------------|
|   |   | 045189   | B. WING _              |   |                        | C<br><b>07/27/2015</b>     |
|   | ROVIDER OR SUPPLIER   | BILITATION, LLC  |                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br>900 MAGNOLIA RD<br>CAMDEN, AR 71701                |                        | 0112112010                 |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIEN  | STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)   | ID<br>PREFI<br>TAG     | PROVIDER'S PLAN OF CORK  (EACH CORRECTIVE ACTION S  CROSS-REFERENCED TO THE AI  DEFICIENCY) | SHOULD BE              | (X5)<br>COMPLETION<br>DATE |
| F 224   | for help to redirect [I ADON and [Name] [DON] was able to gwalk him out the rodincreasingly agitated Ativan 1 mg that the #7] became increasingly agitated Ativan 1 mg that the #7] became increasingly agitated Ativan 1 mg that the product of him at the redirected and I show a staff and several staff members and him to ER. The ambulance was dispressed and down and get #7] was given Ativan muscle. Phone [APS message. ER call and [Resident#7] back to [APS Worker #1] and geri-psych. facility who be partmental Notes the resident was train p.m.  h. On 7/24/15 licens was asked if she would also have a saked if she would | one another and I had to call Resident #7]. The [Name] DON entered the room. The get [Resident #7] attention and om. [Resident #7] became d, would not take the oral e LPN was offering. [Resident ingly verbally threatening to off members stated they were his point. He was not able to sought guidance from the was told to call ambulance and he ER was contacted and the patched to the facility. It took ers to get [Resident #7] to conto the stretcher. [Resident hind 1 mg IM in right deltoid is Worker #1] and left and stated they were sending to the facility. I spoke with did will seek placement at with her approval of facility"  Is dated 7/23/15 documented insferred out of facility at 7:00 and the Certified LPN stated, "Yes for 3 1/2 as asked if she had had aimer Unit. The LPN stated, a ted to the Certified Alzheimer | F2                     | 224   |                        |                            |

|                          | OF DEFICIENCIES<br>F CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  | (X2) MULTIPLE CONSTRUCTION  A. BUILDING |        |  | (X3) DATE SURVEY<br>COMPLETED |                            |
|--------------------------|--|---|---|--------|--|-------------------------------|----------------------------|
|                          |  |   |   |        |  | (                             | C                          |
|                          |  | 045189  | B. WING                                 |        |  | 07/                           | 27/2015                    |
| NAME OF P                | ROVIDER OR SUPPLIER  |   | ,                                       | STREET | ADDRESS, CITY, STATE, ZIP CODE   |                               |                            |
| PINE HII I               | S HEALTH AND REH   | ARILITATION LLC   |   | 900 MA | GNOLIA RD  |                               |                            |
| FINE HILL                | -5 IILALIII AND KLII   | ABILITATION, LEG  |   | CAMDE  | EN, AR 71701   |                               |                            |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIE  | ' STATEMENT OF DEFICIENCIES<br>NCY MUST BE PRECEDED BY FULL<br>DR LSC IDENTIFYING INFORMATION)  | ID<br>PREFI<br>TAG                      | x      | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD B<br>CROSS-REFERENCED TO THE APPROPRI<br>DEFICIENCY) |                               | (X5)<br>COMPLETION<br>DATE |
| F 224                    | tube], catheter or vidiagnosis of Deme psychiatric diagnosis of Deme psychiatric diagnosis was Resident #7 be would wander in a rooms, he had troughad behaviors, but better than other place was asked if Reside point that he had to stated, "Yes, there have to be medical behaviors escalated. The LPN was asked The LPN was asked The LPN stated the behaviors. The LP reported to anyone episodes of the resistated, "Yes, I spounit Director." The criteria for giving remedications. The Identification of the physician when medication for seven behaviors of agitat responsible party in the Certified Alz for 1 year. The LP training for the Certified that the would hand out an | age 48 ouldn't have GT [gastronomy wounds. The should have a entia and shouldn't have sis. The LPN was asked what we haviors. The LPN stated, "He and out of other residents able finding the bathroom. He is I was able to control him eople. He got agitated, he and pick up things." The LPN dent #7's behaviors got to a conhave medications. The LPN were periods that he would ted. Then all of a sudden his ed, they had been random." He was asked if she had talked to anyone. He conditions as we concern the provide the sident's behaviors. The LPN was asked if she had else regarding the increased sident's behaviors. The LPN was asked what was the esidents the PRN [as needed] LPN stated, "We try redirection, to 1 with him before we give the else LPN was asked, "Did you call in the resident received PRN eral days and the resident's ion had increased and was the notified." The LPN stated N was asked regarding the dentified Alzheimer Unit. The LPN despecialized training and former Alzheimer Unit Director differ the less were given on the N was asked regarding | F                                       | 224    |  |                               |                            |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING |  | (>  | (X3) DATE SURVEY<br>COMPLETED |   |                              |                        |
|--|--|---|-------------------------------|---|------------------------------|------------------------|
|  |  | 045189  | B. WING                       |   |                              | C<br><b>07/27/2015</b> |
|  | ROVIDER OR SUPPLIER  |   |                               | STREET ADDRESS, CITY, STATE, ZIP COD<br>900 MAGNOLIA RD<br>CAMDEN, AR 71701 | I                            | 07/27/2015             |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIE  | STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)   | ID<br>PREFI<br>TAG            |   | N SHOULD BE<br>E APPROPRIATE | (X5) COMPLETION DATE   |
| F 224  | Resident #7 's bel "At times he can b you have to redired what kind of behave LPN stated, "Verbad do something to you down and sometime calm him down." of threats did the redirect threaten to hit. The documentation that The LPN stated, "I threaten to hit staff asked if she had re The LPN stated, "I was asked if she ha responsibility party behaviors. The LP The LPN was asked resident 's aggres been reported?" T called the Supervis asked where this w stated, "It's not do asked if the other is stated, "Not at that gave him medication should a resident to Alzheimer Unit with LPN stated, "No." LPN stated, "No, the danger."  At 1:35 p.m., LPN the Certified Alzhe "Yes on the 11-7 s had training for the | viors. The LPN was asked what naviors were. The LPN stated, ecome verbally abusive and ct him." The LPN was asked viors the resident exhibited. The all threats that he was going to bu. Sometimes he would calm hes he required medication to The LPN was asked what kind esident make, did the resident | F                             | 224   |                              |                        |

| OLIVILIV      | OT OIL WILDIO, WE G           | WEDIO/ ND CEITVICEC  |             |            |  | CIVID IVC         | 7. 0000 000 I      |
|---------------|-------------------------------|--|-------------|------------|--|-------------------|--------------------|
|               | OF DEFICIENCIES<br>CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:         | I ` ′       |            | E CONSTRUCTION   | (X3) DATE<br>COMP | SURVEY<br>PLETED   |
|               |                               |  | 7.1. 50.25  |            |  | 1 ,               | С                  |
|               |                               | 045189   | B. WING     |            |  |                   | 27/2015            |
| NAME OF P     | ROVIDER OR SUPPLIER           |  |             | S          | STREET ADDRESS, CITY, STATE, ZIP CODE  |                   |                    |
| 50.5          |                               |  |             | 9          | 00 MAGNOLIA RD   |                   |                    |
| PINE HILL     | S HEALTH AND REHAB            | ILITATION, LLC   |             |            | CAMDEN, AR 71701   |                   |                    |
| (X4) ID       | SUMMARY ST                    | ATEMENT OF DEFICIENCIES                                    | ID          | •          | PROVIDER'S PLAN OF CORRECTION  |                   | (X5)               |
| PREFIX<br>TAG | ,                             | Y MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION) | PREF<br>TAG |            | (EACH CORRECTIVE ACTION SHOULD B<br>CROSS-REFERENCED TO THE APPROPRIA<br>DEFICIENCY) |                   | COMPLETION<br>DATE |
| F 224         | Continued From page           | a 50   |             | 224        |  |                   |                    |
|               |                               | N was asked if she had been                                |             | <b>224</b> |  |                   |                    |
|               |                               | th aggressive resident. The                                |             |            |  |                   |                    |
|               | _                             | nis facility, but elsewhere."                              |             |            |  |                   |                    |
|               | · ·                           | if there were any issues                                   |             |            |  |                   |                    |
|               |                               | or aggressive residents on                                 |             |            |  |                   |                    |
|               |                               | he LPN stated, "Yes with                                   |             |            |  |                   |                    |
|               |                               | is the only issue. He was                                  |             |            |  |                   |                    |
|               | doing fine, then he ha        | ad periods of agitation and                                |             |            |  |                   |                    |
|               | not easily redirected.        | " The LPN was asked what                                   |             |            |  |                   |                    |
|               |                               | ors were. The LPN stated,                                  |             |            |  |                   |                    |
|               |                               | ndow, no major problems                                    |             |            |  |                   |                    |
|               | -                             | The LPN was asked what                                     |             |            |  |                   |                    |
|               | · ·                           | stated, "I was at the Nursing                              |             |            |  |                   |                    |
|               |                               | came to the Nursing Station                                |             |            |  |                   |                    |
|               | followed him back to          | body had attacked him. I                                   |             |            |  |                   |                    |
|               |                               | on the bed with blood all over                             |             |            |  |                   |                    |
|               |                               | 7] out of the room. I got                                  |             |            |  |                   |                    |
|               |                               | he room, I got her sent to the                             |             |            |  |                   |                    |
|               |                               | m]. When [Resident #7]                                     |             |            |  |                   |                    |
|               |                               | Station he was not showing                                 |             |            |  |                   |                    |
|               | any signs or sympton          | ns of aggression. I asked                                  |             |            |  |                   |                    |
|               |                               | appened. [Resident #7]                                     |             |            |  |                   |                    |
|               |                               | in the face. " The LPN was                                 |             |            |  |                   |                    |
|               |                               | nappen. The LPN stated, "It                                |             |            |  |                   |                    |
|               |                               | 30 a.m. on 7/21/15." The                                   |             |            |  |                   |                    |
|               |                               | re had been any aggressive                                 |             |            |  |                   |                    |
|               | •                             | The LPN stated no resident                                 |             |            |  |                   |                    |
|               | to resident contact, b        | easily redirected. The LPN                                 |             |            |  |                   |                    |
|               | was asked where was           |  |             |            |  |                   |                    |
|               |                               | n this incident occurred. The                              |             |            |  |                   |                    |
|               | , ,                           | A was on the back unit                                     |             |            |  |                   |                    |
|               | '                             | A with a resident. The LPN                                 |             |            |  |                   |                    |
|               |                               | nit was staffed. The LPN                                   |             |            |  |                   |                    |
|               |                               | CNA'S. There is one CNA                                    |             |            |  |                   |                    |
|               | -                             | CNA on the back. The CNA                                   |             |            |  |                   |                    |
|               | was off the unit." The        | e LPN stated, "I was at the                                |             |            |  |                   |                    |
|               | Nursing Station." The         | e LPN was asked if she                                     |             |            |  |                   |                    |

|                          | OF DEFICIENCIES<br>CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  | (X2) MULT<br>A. BUILDIN | IPLE CONSTRUCTION  NG  |          | TE SURVEY<br>MPLETED       |
|--------------------------|--|---|-------------------------|--|----------|----------------------------|
|                          |  | 045189  | B. WING _               |  |          | C<br>07/ <b>27/2015</b>    |
|                          | ROVIDER OR SUPPLIER  S HEALTH AND REHA   |   |                         | STREET ADDRESS, CITY, STATE, ZIP CODE 900 MAGNOLIA RD CAMDEN, AR 71701                     |          | 1112112015                 |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIEN   | STATEMENT OF DEFICIENCIES<br>ICY MUST BE PRECEDED BY FULL<br>R LSC IDENTIFYING INFORMATION)   | ID<br>PREFI)<br>TAG     | PROVIDER'S PLAN OF CORF ( (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY) | HOULD BE | (X5)<br>COMPLETION<br>DATE |
| F 224                    | front hall where [Re located." The LPN had any behaviors. generally didn't war she get up at night.' Resident #7 had an stated, "He did war sleeping, but that m The LPN was asked unit only has 1 CNA the front hall and 1 residents. The LPN i. On 7/23/15, Certifinterviewed:  At 7:50 p.m., Certifinterviewed:  At 7 | hall. The LPN stated, "Not the sident #7 and #8] were was asked if [Resident #8] The LPN stated, "She ider, once in a blue moon did 'The LPN was asked if y behaviors at night. The LPN inder at night, he had started orning he was getting up." It regarding the staffing, the at night, for 18 residents on CNA on the back unit for 9 | F2                      | 224  |          |                            |

|                          | OF DEFICIENCIES<br>F CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  | (X2) MULTI<br>A. BUILDIN | PLE CONSTRUCTION  G   |                                   | ATE SURVEY<br>DMPLETED     |  |
|--------------------------|---|---|--------------------------|---|-----------------------------------|----------------------------|--|
|                          |   | 045189  | B. WING                  |   |                                   | C                          |  |
|                          | ROVIDER OR SUPPLIER   |   |                          | STREET ADDRESS, CITY, STATE, ZIP CODE 900 MAGNOLIA RD CAMDEN, AR 71701                            | - <b>07/27/2015</b> ATE, ZIP CODE |                            |  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIEN  | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG      | PROVIDER'S PLAN OF CORR<br>(EACH CORRECTIVE ACTION S<br>CROSS-REFERENCED TO THE AF<br>DEFICIENCY) | HOULD BE                          | (X5)<br>COMPLETION<br>DATE |  |
| F 224                    | would get someone When asked about he stated, "Yes, at time did try to hit me, but The CNA was asked afraid of him and he aggressive do you fe another resident. The down to it." The CNA reported the inciden aggressive. The CNA The CNA was asked was afraid of the resistated, "No."  At 7:58 p.m., CNA # the Certified Alzhein "Yes." The CNA was training for the Certistated, "I worked he I've not started the trasked if she had car stated, "Yes, togethe CNA was asked about The CNA stated, "Hi got real agitated. He him. He would talk li give him care. He working. He would watch him, he would resident's room. He towards staff." The resident tried to hit so When asked if the retowards residents, the control of | else. He would yell at us." her fear of resident, the CNA is he was aggressive and he he was more threatening." It since you stated you were would become more heel that he could have hit he CNA stated, "If it came ha was asked if she had hat so f the resident being hat A stated, "Yes, to the Nurse." If if she had reported that she hident at times. The CNA  was asked if she worked on her Unit. The CNA stated, hasked if she had received heel didn't like people bothering hat he wouldn't let us has in a mind that he was walk all the time. We had to he taff. The CNA stated, "Yes." he cond aggressive he CNA stated, "Yes." he cond aggressive he CNA stated, "No." | F 2                      | 24  |                                   |                            |  |

|                          | OF DEFICIENCIES<br>CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  | (X2) MULT<br>A. BUILDIN | PLE CONSTRUCTION  IG   |          | DATE SURVEY<br>COMPLETED   |
|--------------------------|--|---|-------------------------|--|----------|----------------------------|
|                          |  | 045189  | B. WING _               |  |          | C<br>07/27/2015            |
|                          | ROVIDER OR SUPPLIER  | BILITATION, LLC   |                         | STREET ADDRESS, CITY, STATE, ZIP CODE  900 MAGNOLIA RD  CAMDEN, AR 71701                 |          |                            |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIEN   | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG     | PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY) | HOULD BE | (X5)<br>COMPLETION<br>DATE |
| F 224                    |  | oriate for the Certified e DON stated, "I was not   | F 2                     | 24   |          |                            |
|                          | documentation at the DON was asked if some resident's aggressive the resident's clinical was aware of his paresident room. I was behaviors towards some DON was shown that the resident had threatening the staff DON stated, "I was asked if the resident aggressive behavior DON stated, "No." To resident is having in aggressive behavior Physician and the restated, "Yes." The Dincreased episodes | at time of admission." The he was aware of the e behaviors documented in all record. The DON stated, "I cing and going in other and aware of his aggressive taff and other residents." The edocumentation on 5/2/15 diballed up his fist and was and other residents. The not aware." The DON was asked if a creased episodes of a shouldn't this be reported to esponsible party. The DON ON was asked if the of aggressive behaviors residents on the Alzheimer's |                         |  |          |                            |
|                          | Unit Director (ACUD criteria for admission Unit. The ACUD star age, diagnosis of Ala a certain level of fun ambulating. The advanced require more superv " How do you staff?' days they have 2 or back and evening the on the back on 11-7   | 5 p.m., the Alzheimer Care b) was asked regarding the n to the Certified Alzheimer ted, they have to be a certain zheimer's or Dementia, have actioning and self-mobile or vanced unit has residents that in the disease process and rision. The ACUD was asked, The ACUD stated that on 3 on the front and 1 on the ey have 2 on the front and Nurse for the front and back  |                         |  |          |                            |

|                          | OF DEFICIENCIES<br>F CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  | (X2) MULTIPLE CONSTRUCTION A. BUILDING |  | · ,                            | (X3) DATE SURVEY<br>COMPLETED |  |
|--------------------------|--|---|--|--|--------------------------------|-------------------------------|--|
|                          |  | 045189  | B. WING _                              |  | 0                              | C<br><b>7/27/2015</b>         |  |
|                          | ROVIDER OR SUPPLIER  | HABILITATION, LLC   |  | STREET ADDRESS, CITY, STATE, ZIP CO<br>900 MAGNOLIA RD<br>CAMDEN, AR 71701       | •                              | 772772010                     |  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICI   | Y STATEMENT OF DEFICIENCIES<br>ENCY MUST BE PRECEDED BY FULL<br>OR LSC IDENTIFYING INFORMATION)   | ID<br>PREFI<br>TAG                     | PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTIVE) CROSS-REFERENCED TO THE DEFICIENCY | ON SHOULD BE<br>HE APPROPRIATE | (X5)<br>COMPLETION<br>DATE    |  |
| F 224                    | reported any aggribehaviors regardistated, "No." The had increased bel medicated who should be a stated that they should be a stated that they should be a notified. The ACU had been notified 7/21/15. The ACU and responsible phad increased belshe had not notified worker #1] until 7/ what was the impophysician of the resident." The ACUD stated resident." The ACUD stated resident. The ACUD stated resident. The ACUD stated resident. The have called for guif a resident with F Schizophrenia be Alzheimer Unit. The action of the resident with F Schizophrenia be Alzheimer Unit. The action of the resident with F Schizophrenia be Alzheimer Unit. The action of the resident with F Schizophrenia be Alzheimer Unit. The action of the resident with F Schizophrenia be Alzheimer Unit. The action of the resident with F Schizophrenia be Alzheimer Unit. The action of the resident with F Schizophrenia be Alzheimer Unit. The action of the resident with F Schizophrenia be Alzheimer Unit. The action of the resident and attached to the Care) Incident and dated 7/21/15. The had contacted [Principles of the resident and dated 7/21/15. The had contacted [Principles of the resident and dated 7/21/15. The had contacted [Principles of the resident and dated 7/21/15. The had contacted [Principles of the resident and dated 7/21/15. The had contacted [Principles of the resident who are resident with F Schizophrenia be action of the resident with F | page 54 The ACUD was asked if the staff ressive behaviors or increased and Resident #7. The ACUD ACUD was asked if a resident reaviors that required to be rould they report to. The ACUD and they report to the Nurse and the ACUD was asked if the ponsible party should be D stated, "Yes. I thought they when the incident occurred on D was asked was the Physician arty notified when Resident #7 haviors. The ACUD stated that ed the responsible party [APS 23/15. The ACUD was asked ortance of notifying the resident increased behaviors.  The ACUD stated, "I was he resident out." The ACUD had called the Physician or the when she was trying to transfer ACUD stated, "No, I should idance." The ACUD was asked expendituded to the Certified he ACUD stated, "I would say hed to deal with them."  30 p.m., the Administrator was he documentation on a letter 15, signed by the Administrator, he OLTC (Office of Long Term of Accident Report (1&A) form the Administrator stated that they havisian #1] to place a referral The documentation stated that | F                                      | 224  |                                |                               |  |

|                          | OF DEFICIENCIES<br>CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  | ` ′                 | IPLE CONSTRUCTION  | \ , ,                          | TE SURVEY<br>MPLETED       |
|--------------------------|--|---|---------------------|--|--------------------------------|----------------------------|
|                          |  | 045189  | B. WING _           |  | 0                              | C<br>7/ <b>27/2015</b>     |
|                          | ROVIDER OR SUPPLIER  | HABILITATION, LLC   |                     | STREET ADDRESS, CITY, STATE, ZIP CO<br>900 MAGNOLIA RD<br>CAMDEN, AR 71701       | RESS, CITY, STATE, ZIP CODE    |                            |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICI   | Y STATEMENT OF DEFICIENCIES<br>ENCY MUST BE PRECEDED BY FULL<br>OR LSC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTIVE) CROSS-REFERENCED TO THE DEFICIENCY | ON SHOULD BE<br>HE APPROPRIATE | (X5)<br>COMPLETION<br>DATE |
| F 224                    | aggressive behave very remorseful for has repeatedly as ok?" The letter is to review this information resident from being geri-psych admission asked if the Residing given orders for the stated, "No." The staff had reported documented incided record of aggression Administrator states was asked regard letter referring to the diagnosis of Alzhe 47] had diagnosis Administrator states was asked if she was asked if s | not displayed any s/s of ior at this time and that he was or the events that took place and eked staff, "How is she? Is she tated [Physician #1] has agreed rmation in attempt to prevent ag placed outside the facility in sion. The Administrator was lent's attending Physician had the referral. The Administrator Administrator was asked if the to her the frequently ent in the resident's clinical live behaviors. The ed, "No." The Administrator ling the documentation in the elimer's Disease and if [Resident of Alzheimer's Disease. The ed, "No." The Administrator had reviewed the resident's fine staff had reported to her umented incident in the resident aggressive behavior. The | F2                  | 224  |                                |                            |

|                          | OF DEFICIENCIES<br>F CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   |                    |  |                                | (X3) DATE SURVEY<br>COMPLETED |  |
|--------------------------|--|--|--------------------|--|--------------------------------|-------------------------------|--|
|                          |  | 045189   | B. WING _          |  | 0                              | C<br>7/ <b>27/2015</b>        |  |
|                          | ROVIDER OR SUPPLIER  | IABILITATION, LLC  |                    | STREET ADDRESS, CITY, STATE, ZIP CO<br>900 MAGNOLIA RD<br>CAMDEN, AR 71701             |                                | 772772010                     |  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICI   | Y STATEMENT OF DEFICIENCIES<br>ENCY MUST BE PRECEDED BY FULL<br>OR LSC IDENTIFYING INFORMATION)  | ID<br>PREFI<br>TAG | PROVIDER'S PLAN OF C<br>(EACH CORRECTIVE ACTIC<br>CROSS-REFERENCED TO TH<br>DEFICIENCY | ON SHOULD BE<br>HE APPROPRIATE | (X5)<br>COMPLETION<br>DATE    |  |
| F 224                    | resident to resided Resident #7 and the was advised 7/23 hospital staff after was advised by [Athen afterwards.] hospital called End kicked a 102 yfound that out after Room I did an of [County] Sheriff of for transport as soft The APS Casework behavior incidents been taken with Research Caseworker #1 stameds and we coubehaviors sooner asked if notified of behaviors that incident yester nurse [Emergency that incident yester nurse [Emergency that incident soon arrangements to sany aggressive before the staffing ratio. The documentation in with the ratios for | was notifed on 7/21/15 of any not altercation that involved he Caseworker stated, "No. I will be a call from them. I will be the caseworker stated, "No. I will be a call from them. I will be a call from them. I will be a call after the case of the way on Tuesday [7/21/15] will be a call earlier to the series of the went to the Emergency of the West to the Emergency of the West to the West t | F:                 | 224  |                                |                               |  |

|                          | DF DEFICIENCIES<br>CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  | , ,                |     | E CONSTRUCTION  | (X3) DATE SURVEY<br>COMPLETED |                            |
|--------------------------|--|--|--------------------|-----|---|-------------------------------|----------------------------|
|                          |  | 045189   | B. WING            |     |   | l                             | 27/2045                    |
| NAME OF D                | ROVIDER OR SUPPLIER  | 0.0.00   |                    |     | STREET ADDRESS, CITY, STATE, ZIP CODE   | 071                           | 27/2015                    |
|                          | S HEALTH AND REHABI  | ILITATION, LLC   |                    | 9   | 00 MAGNOLIA RD<br>CAMDEN, AR 71701  |                               |                            |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)   | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)   | ID<br>PREFI<br>TAG |     | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) |                               | (X5)<br>COMPLETION<br>DATE |
| F 282<br>SS=E            | evening and night ration The ADON stated, "I'ven Don 7/27/15 at 4:30 asked what the admist Certified Alzheimer Ustated, "The IDT [Interest as a group to see if the met." The Administrated documentation of this stated, "We don't kee Regarding [Resident: did have a meeting propose of the Surveyor stated in states at they do not recall have [Resident #7]. The Administrated of the former ACD prior to admission, but Dementia." The Administration the resident ago that the age is case be was asked about the admission to the Certified Alzheimer stated, "The facility has since that time." The the requirements from Certified Alzheimer United The Administrator stated with corporate." As of additional information 483.20(k)(3)(ii) SERV PERSONS/PER CAR | p.m., the Administrator was sision criteria was for the nit. The Administrator erdisciplinary] team meets are Residents needs can be for was asked if they had meeting. The Administrator p this documentation, #7] I do believe that the IDT rior to the admission." The aff interviews staff stated ing a meeting regarding diministrator stated, "I don't allow went to meet with him the had the diagnosis of inistrator was asked what the e. The Administrator stated y case. The Administrator Policy and Procedure for iffied Alzheimer Unit for eetings and the staffing for the regulation for the nit would not have changed. The had they case the regulation for the nit would not have changed. The had they case the received. Transpective designs and the staffing for the nit would not have changed. The had they can be received. Transpective designs and the regulation for the nit would not have changed. The regulation for the nit would not have changed. The planspective designs are received. Transpective designs are received. Transpective designs are received. Transpective designs are received. Transpective designs are received. The planspectic designs are received. The pl |                    | 224 |   |                               |                            |

|                          | OF DEFICIENCIES<br>CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   | (X2) MULTI<br>A. BUILDIN   | PLE CONSTRUCTION  G  |              | DATE SURVEY<br>COMPLETED   |
|--------------------------|--|--|--|--|--------------|----------------------------|
|                          |  | 045189   | B. WING _  |  |              | C<br>07/27/2015            |
|                          | ROVIDER OR SUPPLIER S HEALTH AND REHAB   | ILITATION, LLC   | STREET ADDRESS, CITY, STATE, ZIP CODE 900 MAGNOLIA RD CAMDEN, AR 71701 |  | 1 01/21/2013 |                            |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC  | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG  | PROVIDER'S PLAN OF CORR<br>(EACH CORRECTIVE ACTION SI<br>CROSS-REFERENCED TO THE AP<br>DEFICIENCY) | HOULD BE     | (X5)<br>COMPLETION<br>DATE |
| F 282                    | Continued From pag care.   | e 58   | F 2  | 82   |              |                            |
|                          | by: Complaint 20354 (A substantiated, all or i Based on observatio interview, the facility were administered as treat an infection and medication error for (Resident #2, #4 and had an order for an amedication was adm 2 halls to prevent a s for 1 (Resident #4) o #6, #8, #9, #10 and # received medications | n part, in these findings.  n, record review, and failed to ensure medications s ordered to appropriately prevent a significant  |  |  |              |                            |
|                          | who had an order for the Resident Census received on 7/21/15 areceived medications to the list received fro (DON) on 7/23/15.  Resident #4 had diagoperession. The Quawith an Assessment documented the residue severely impaired) on Mental Status, requir person for bed mobil assistance of 1 person          | an antibiotic according to and Conditions of Residents and 32 residents who on the East Hall, according om the Director of Nurses The findings are.  Ignoses of Schizophrenia and arterly Minimum Data Set Reference Date of 4/29/15 dent scored 0 (0-7 indicates in the Brief Interview for ed limited assistance of one ity and transfers, extensive on for personal hygiene, was t of bladder, occasionally and was at risk for |  |  |              |                            |

|                          | OF DEFICIENCIES CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  | ` ′                 | LE CONSTRUCTION   | (X3) DATE SURVEY COMPLETED |  |  |
|--------------------------|--|---|---------------------|---|----------------------------|--|--|
|                          |  | 045189  | B. WING             |   | C<br>07/27/2015            |  |  |
|                          | ROVIDER OR SUPPLIER  | BILITATION, LLC   |                     | STREET ADDRESS, CITY, STATE, ZIP CODE 900 MAGNOLIA RD CAMDEN, AR 71701                                  | 1 0112110                  |  |  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC  | TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORREC<br>(EACH CORRECTIVE ACTION SHO<br>CROSS-REFERENCED TO THE APPF<br>DEFICIENCY) | ULD BE COMPLETION          |  |  |
| F 282                    | Continued From pag   | e 59  | F 28                | 2   |                            |  |  |
|                          | the resident returned with a physician orde                              | po (by mouth) q (every) 12  |                     |   |                            |  |  |
|                          | "Culture Urine Gram<br>than]10,000 cfu/ml [c<br>milliliter]." Handwritte | ted for 5/27/15 documented, negative bacilli < [less colony forming units per en on the lab report was alle by mouth q 12 (hours) x |                     |   |                            |  |  |
|                          | Record (MAR) docur started on 5/26/15 ar                                 | edication Administration<br>mented, Keflex 500 mg was<br>nd was administered, per<br>5/26/15, -5/31/15 at 6:00 a.m.<br>s.           |                     |   |                            |  |  |
|                          | mg was administered 6/1/15 and 6/2/15 at                                 | AR documented Keflex 500 d, per nurses initials, on 8:00 a.m. and 8:00 p.m., 2 as adminisntered for 8 days s ordered.               |                     |   |                            |  |  |
|                          | "Orders to decreas   | ed 5/30/15 documented,<br>le Haldol from 10 mg to 5 mg<br>S 2 mg from BID [two times<br>me]"  |                     |   |                            |  |  |
|                          | "Start Date 5/29/15 E  | ated 5/29/15 documented,<br>Benztropine Mes [Mesylate] 2<br>by mouth evening. For<br>enia."   |                     |   |                            |  |  |
|                          | 1) The May 2015 MA<br>handwritten order for<br>[every evening]" and      | , "Benztropine tablet 1 po Q  |                     |   |                            |  |  |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |   |  | E CONSTRUCTION      | (X3) DATE SURVEY<br>COMPLETED   |                 |
|---|---|--|---------------------|---|-----------------|
|   |   | 045189   | B. WING             |   | C<br>07/27/2015 |
|   | ROVIDER OR SUPPLIER   | ABILITATION, LLC   | g                   | STREET ADDRESS, CITY, STATE, ZIP CODE<br>00 MAGNOLIA RD<br>CAMDEN, AR 71701                                       | 01/21/2010      |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIE   | STATEMENT OF DEFICIENCIES<br>NCY MUST BE PRECEDED BY FULL<br>R LSC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROPE<br>DEFICIENCY) | BE COMPLETION   |
| F 282   | mouth twice a day Date 5/12/15, Start reduce the Benztrowas not transcribed Benztropine MES vinitials, as being ac 6/1/15-6/30/15 and and 6/9/15 - 6/30/1 circled as not giver documented on the "6/4/15 Benztropine reorder through [Prinitialed by License "6/5/15 Benztropine through [Pharmacy was initialed by LP "6/6/15 Benztropine [reorder again]."  "6/7/15 Benztropine [reorder again]." | rted on 5/29/15.  MAR documented, 2 mg tablet one tablet by at 8 a.m. and 4:00 p.m., Order Date - 5/13/15." The order to pine Mesylate to once daily d to the June 2015 MAR. The was documented, by nurses's lministered at 8:00 a.m. from 4:00 p.m. on 6/1/15- 6/3/15 5. The 4:00 p.m. time was a from 6/4/15 - 6/8/15 and b back of the MAR:  2 mg unavailable. Need to harmacy]" This entry was d Practical Nurse (LPN) #3.  2 mg unavailable Re-ordered but not received." This entry N #3.  2 unavailable again RO  2 unavailable."  2 unavailable."  3 unavailable." | F 282               |   |                 |
|   | 6/7 when no Benzt the facility.  c. On 7/24/15 at 8:  | ered at 8:00 a.m. from 6/4 - ropine 2 mg was available in 50 a.m., Licensed Practical as asked if a medication was   |                     |   |                 |

PRINTED: 08/10/2015 FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY

|                          | DF DEFICIENCIES<br>CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  | 1 ' '              | TIPLE CONSTRUCTION  NG   | 1' '  | (X3) DATE SURVEY<br>COMPLETED |  |
|--------------------------|---|---|--------------------|--|-------|-------------------------------|--|
|                          |   | 045189  | B. WING            |  | 07    | C<br><b>//27/2015</b>         |  |
|                          | ROVIDER OR SUPPLIER   | ILITATION, LLC  | •                  | STREET ADDRESS, CITY, STATE, ZIP CODE<br>900 MAGNOLIA RD<br>CAMDEN, AR 71701 | •     |                               |  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)  | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)   | ID<br>PREFI<br>TAG |  | LD BE | (X5)<br>COMPLETION<br>DATE    |  |
| F 309<br>SS=E            | "If med [medication] is pharmacy to get it and call [local pharmacy]." reorder the med and i [local pharmacy]." The doses of the antibiotic stated, "Yes, so that it not given, the infection of the month changethe med cart and the Records?" The DON shack with the Physicia and the medication of "Do you check the Physicia and the medication of "Do you check the Physicia and the facility did DON stated, "No."  483.25 PROVIDE CA HIGHEST WELL BEIL Each resident must reprovide the necessary or maintain the higher mental, and psychosolaccordance with the cand plan of care.  This REQUIREMENT by: Complaint #20354 (A | lo you do?" The LPN stated, is not available call the dif we have to after hours. If it's a routine med you can if it doesn't arrive you call he LPN was asked should all to be administered. The LPN it will kill the infection and, if in could come back."  I p.m., the Director of How did you perform the end you for the medications in Medication Administration stated, "We do a match an Orders and the MARs art." The DON was asked, hysician Orders with the stated, "Yes." The DON was do 24-hour chart checks. The ARE/SERVICES FOR NG  RECEIVE and the facility must by care and services to attain st practicable physical, ocial well-being, in comprehensive assessment  ARO0018459) and Complaint 6) substantiated, all or in |                    | 309  |       |                               |  |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |  | ` ′   | PLE CONSTRUCTION  G |  | (X3) DATE SURVEY<br>COMPLETED  |                            |
|---|--|---|---------------------|--|--------------------------------|----------------------------|
|   |  | 045189  | B. WING             |  |                                | C                          |
|   | ROVIDER OR SUPPLIER  |   |                     | STREET ADDRESS, CITY, STATE, ZIP CO<br>900 MAGNOLIA RD<br>CAMDEN, AR 71701             |                                | 7/27/2015                  |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIENC  | TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF C<br>(EACH CORRECTIVE ACTIV<br>CROSS-REFERENCED TO TH<br>DEFICIENCY | ON SHOULD BE<br>HE APPROPRIATE | (X5)<br>COMPLETION<br>DATE |
| F 309   | failed to ensure the pregarding non-therap #2) of 2 (Resident #2 residents in the facility for Dilantin levels. The ensure the physician withholding of schedi #9) of 2 (Residents # residents who had so failed practice had the residents who receive Physician Orders for a list received from the fast ordered as documen DON on 7/27/15. The 1. Resident #2 had detailed the resident who receive the form the fast ordered as documen form the fast ordered | ew and interview, the facility obysician was consulted peutic lab levels 1 (Resident 2 and #10) case mix ty who had Physician Orders the facility also failed to was consulted regarding the uled insulin for 1 (Resident 89 and #11) case mix cheduled insulin doses. This is e potential to affect 3 ed Dilantin and had Dilantin Levels according to the Director of Nurses (DON) the potential to affect 6 the Wing who had insulin ted on a list provided by the e findings are: | F3                  | 09   |                                |                            |
|   | Dementia and Convu Minimum Data Set (Na Reference Date (ARI resident scored 5 (0-impaired) on the Brie required extensive as personal hygiene, and bowel and bladder.  a. The July 2015 Phy "Dilantin 100 mg [mil po [by mouth] daily a Level Q [every] 3 mo January)."  | ulsions. The Quarterly MDS) with Assessment D) 7/14/15 documented the 7 indicates severely of Interview for Mental Status, assistance of 1 person for od was always incontinent of visician Orders documented, ligram] capsule one capsule t 0800 a.m. and Dilantin onths (April, July, October,  |                     |  |                                |                            |

PRINTED: 08/10/2015 FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY

|                          | DF DEFICIENCIES<br>CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   | (X2) MULTIPLE CONSTRUCTION ( A. BUILDING |     | (X3) DATE<br>COMP  | SURVEY<br>LETED |                            |
|--------------------------|---|--|--|-----|--|-----------------|----------------------------|
|                          |   | 045189   | B. WING                                  |     |  | l               | 27/ <b>2015</b>            |
|                          | ROVIDER OR SUPPLIER  S HEALTH AND REHAB   | ILITATION, LLC   | ,  | 9   | TREET ADDRESS, CITY, STATE, ZIP CODE<br>00 MAGNOLIA RD<br>CAMDEN, AR 71701   |                 |                            |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)  | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION)  | ID<br>PREFI<br>TAG                       | ×   | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BI<br>CROSS-REFERENCED TO THE APPROPRIA<br>DEFICIENCY) |                 | (X5)<br>COMPLETION<br>DATE |
| F 309                    | Continued From page   | e 63   | F:                                       | 309 |  |                 |                            |
|                          | 1) 7/29/14 Level 2.5 L  | _ [low]  |  |     |  |                 |                            |
|                          | 2) 10/22/14 Level 2.1   | L [low]  |  |     |  |                 |                            |
|                          | 3) 1/6/15 Level 1.7 L   | [low]  |  |     |  |                 |                            |
|                          | 4) 4/22/15 Level 2.4 L  | _ [low]  |  |     |  |                 |                            |
|                          | documented, "Summon arrival resident has Seizure activity lasted Resident alert able to d. The Nurses Notes documented, "3:30 p room, upon entering r with right sided facial approximately 8 minu weakness and r [right office notified and ord                    |  |  |     |  |                 |                            |
|                          | 5/11/15 at 4:15 p.m. of presents with history unknown number. Chactivity; generalized sonset just prior to arrisuffer any apparent a Phenytoin/Dilantin Lenormal -range (10-20 Dilantin 1 gram IVPB and Rocephin 1 gram Resident was dischar Bronchitis and Adult S | ician Documentation dated documented, "This patient of multiple seizures an aracter of seizure(s): Motor shaking all over. Seizure val The patient did not ssociated injuryThe evel was 2.4 below low )The Resident received [intravenous piggy back] IM [intramuscular].The reged with diagnoses of Seizure, Recurrent (Adult). " |  |     |  |                 |                            |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: |   | (X2) MULTI<br>A. BUILDIN   | PLE CONSTRUCTION  G |   | (X3) DATE SURVEY<br>COMPLETED |                            |
|--|---|--|---------------------|---|-------------------------------|----------------------------|
|  |   | 045189   | B. WING _           |   |                               | C<br>07/27/2015            |
|  | ROVIDER OR SUPPLIER   | BILITATION, LLC  |                     | STREET ADDRESS, CITY, STATE, ZIP CODE 900 MAGNOLIA RD CAMDEN, AR 71701                          | •                             | 0112112013                 |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIEN  | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF COR<br>(EACH CORRECTIVE ACTION S<br>CROSS-REFERENCED TO THE A<br>DEFICIENCY) | SHOULD BE                     | (X5)<br>COMPLETION<br>DATE |
| F 309  | Continued From pag  | ge 64<br>e for reviewing the lab results.  | F 3                 | 09  |                               |                            |
|  | The DON stated, "T of Nurses]." The DC happen when the re the therapeutic range                                 | he ADON [Assistant Director on the ADON [Assistant Director on |                     |   |                               |                            |
|  | look at the lab wher<br>was asked, "If a res<br>is consistently below   | 8 p.m. the ADON stated, "I it is received." The ADON dent has a Dilantin Level that the therapeutic range should tified?" The DON stated,  |                     |   |                               |                            |
|  | Mellitus Uncontrolle<br>Cerebrovascular Ac<br>Dementia. The Qua<br>7/21/15 documented<br>indicates severely in  | diagnoses of Type 2 Diabetes<br>d, Alzheimer's Disease,<br>cident (CVA), and Vascular<br>arterly MDS with an ARD of<br>d the resident scored 4 (0-7<br>anpaired) on the BIMS, had<br>and had received insulin  |                     |   |                               |                            |
|  | "administer my ord<br>my Physician's orde<br>(insulin) give 60 unii<br>[twice a day] Give<br>when I cannot reme | ated 6/25/15 documented,<br>dered medicationsas per<br>rs 6/4/15 Novolin 70-30<br>s sq [subcutaneous] BID<br>me verbal cues/reminders<br>mber 25% may be uneaten<br>aff to assist me observe for<br>."   |                     |   |                               |                            |
|  | an order originally d   | ysician Orders documented<br>ated 6/4/15 "Novolin 70-30<br>iter) vial Give 60 units<br>a day"  |                     |   |                               |                            |
|  | c. On 7/21/15 at 4:3  | 5 p.m., Licensed Practical   |                     |   |                               |                            |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: |   | (X2) MULTIF  | PLE CONSTRUCTION    |   | (X3) DATE SURVEY<br>COMPLETED |                            |
|--|---|--|---------------------|---|-------------------------------|----------------------------|
|  |   | 045189   | B. WING             |   |                               | C<br><b>07/27/2015</b>     |
|  | ROVIDER OR SUPPLIER   | ABILITATION, LLC   |                     | STREET ADDRESS, CITY, STATE, ZIP CODE 900 MAGNOLIA RD CAMDEN, AR 71701                          | •                             | 07/27/2013                 |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIE   | STATEMENT OF DEFICIENCIES<br>NCY MUST BE PRECEDED BY FULL<br>R LSC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF COR<br>(EACH CORRECTIVE ACTION :<br>CROSS-REFERENCED TO THE A<br>DEFICIENCY) | SHOULD BE                     | (X5)<br>COMPLETION<br>DATE |
| F 309  | sugar check on the sugar level was 11s going to give. I don't want her to gwithout snack and cookie." At 4:36 p.r room, went to the repackage that conta oatmeal cookie and bedside. The LPN bedside tablet then room without havin ate the cookie or as medication.  d. The Medication of dated July 2015 do unit/ml vial Give 60 day 6:00 a.m." on 7 given]" and "4:00 p #3] Result 115" The a diagonal slash me. On 7/22/15 at 4:1 Notes were reviewed nursing dated 7/14, entry was dated 7/14 entry was dated 7/15 services. There we nursing that indicated that the proposed for the power of the proposed for 7/22/15 at 5:1 when scheduled instructions results. | rformed a finger-stick blood resident and stated the blood 5. The LPN stated, "I'm not 't feel comfortable giving it but get 60 units Novolin 70/30 bottoming out so I'll get her a m., the LPN left the resident's hurse's station, picked up a ined a soft cream filled direturned to the resident's laid the cookie down on the promptly left the resident's g waited to ensure the resident hy other food with the  Administration Record (MAR) cumented "Novolin 70-30 100 units subcutaneous twice a 7/21/15 "Result 66 Units [none m." the nurse's initial's [LPN e amount of units and site had ark across each of the areas.  30 p.m., the Departmental ed and there was an entry by /15 at 9:27 p.m. and the next 22/15 at 11:26 a.m. by Social as no documentation by ed that the physician was neduled insulin doses were e any telephone orders that hysician was consulted and egarding the insulin.  15 p.m., LPN #3 was asked sulin doses are withheld, in be notified and the LPN | F 30                |   |                               |                            |

PRINTED: 08/10/2015 FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY

|                          | DF DEFICIENCIES<br>CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  | ` ′               |            | E CONSTRUCTION   | (X3) DATE SURVEY<br>COMPLETED |                            |
|--------------------------|--|---|-------------------|------------|--|-------------------------------|----------------------------|
|                          |  | 045189  | B. WING           |            |  |                               | 27/ <b>2015</b>            |
|                          | ROVIDER OR SUPPLIER S HEALTH AND REHAB   |   | <u>. I</u>        | 9          | STREET ADDRESS, CITY, STATE, ZIP CODE  100 MAGNOLIA RD  CAMDEN, AR 71701                                     | <u> </u>                      | 27/2013                    |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC  | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>.SC IDENTIFYING INFORMATION)   | ID<br>PREF<br>TAG |            | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) |                               | (X5)<br>COMPLETION<br>DATE |
| F 309 F 314 SS=E         | the physician was not withheld on 7/21/15 at The LPN was asked inotified each time sch withheld and the LPN g. On 7/27/15 at 4:30 the physician should   | ast." The LPN was asked if tified when the insulin was and the LPN stated, "No." If the physician should be neduled insulin doses are stated, "Yes."  p.m., the DON was asked if the notified if scheduled and the DON stated, NT/SVCS TO |                   | 309<br>314 |  |                               |                            |
|                          | resident, the facility method enters the facility does not develop preindividual's clinical country were unavoidable pressure sores received.  | chensive assessment of a must ensure that a resident without pressure sores ssure sores unless the andition demonstrates that e; and a resident having wes necessary treatment and dealing, prevent infection and own developing.         |                   |            |  |                               |                            |
|                          | by: Complaint #20354 (A all or in part, in these Based on observation interview, the facility the and repositioning pro- incontinence checks the every 2 hours, all skir urine and feces, and during incontinent can | n, record review, and failed to ensure a turning gram was implemented and were completed at least areas were cleaned of plain water was no used   |                   |            |  |                               |                            |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |  | 1 ` ′   | PLE CONSTRUCTION  G | ` '   | (X3) DATE SURVEY<br>COMPLETED |                            |
|---|--|---|---------------------|---|-------------------------------|----------------------------|
|   |  | 045189  | B. WING _           |   |                               | C<br><b>7/27/2015</b>      |
|   | ROVIDER OR SUPPLIER  | ILITATION, LLC  |                     | STREET ADDRESS, CITY, STATE, ZIP COI<br>900 MAGNOLIA RD<br>CAMDEN, AR 71701               |                               | 7/2//2013                  |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIENC  | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CO<br>(EACH CORRECTIVE ACTIO<br>CROSS-REFERENCED TO THI<br>DEFICIENCY) | N SHOULD BE<br>E APPROPRIATE  | (X5)<br>COMPLETION<br>DATE |
| F 314   | #9) case mix resident staff for incontinent of failed to apply skin be care to prevent skin indevelopment of press (Resident #2) case mplanned for barrier or had the potential to a incontinent and 9 resideveloping pressure East Wing according Assistant Director of The findings are:  1. Resident #2 had of Dementia and Convurt Minimum Data Set (Note The Findings are)  1. Resident #2 had of Dementia and Convurt Minimum Data Set (Note The Findings are)  1. Resident #2 had of Dementia and Convurt Minimum Data Set (Note The Findings are)  1. Resident #2 had of Dementia and Convurt Minimum Data Set (Note The Findings are)  1. Resident #2 had of Dementia and Convurt (ARI the resident scored 5 impaired) on the Brie resident required exterperson for personal hincontinent of bowel and developing pressure ulcers.  2. The Comprehensi documented, "Proble assistance with bed resident toileting, personal hydrocomotion. Goal I will cares met by staff on incont. [incontinent] of please give me incontant or pull up please | dent #1, 2, #3, #4, #6 and to who were dependent on are on the East Wing and arrier cream per the plan of critation and potential sure ulcers for 1 of 1 hix resident that was care eam. This failed practice ffect 27 residents who were idents who were at risk for ulcers and resided on the to a list provided by the Nursing (ADON) on 8/10/15.  Itiagnosis of Pre-senile Isions. The Quarterly MDS) with Assessment O of 7/14/15 documented (0-7 indicates severely for Mental Status, ensive assistance of 1 hygiene, was always and bladder, was at risk for ulcers, and had no pressure we Care Plan dated 10/13/14 m/Need, I require extensive nobility, transfers, dressing, | F3                  | 14  |                               |                            |

|                          | OF DEFICIENCIES F CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  | 1 ' '               | LE CONSTRUCTION  | (X3     | ) DATE SURVEY<br>COMPLETED |
|--------------------------|--|---|---------------------|--|---------|----------------------------|
|                          |  | 045189  | B. WING             |  |         | C<br><b>07/27/2015</b>     |
|                          | ROVIDER OR SUPPLIER  |   |                     | STREET ADDRESS, CITY, STATE, ZIP CODE 900 MAGNOLIA RD CAMDEN, AR 71701                               | ı       | 0//2//2015                 |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC  | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRE<br>(EACH CORRECTIVE ACTION SH<br>CROSS-REFERENCED TO THE APP<br>DEFICIENCY) | OULD BE | (X5)<br>COMPLETION<br>DATE |
| F 314                    | "Problem/need At risl [related to] impaired in B&B. Goal I will not econditions r/t inconting me Q 2 H [hours] and barrier cream applica PRN as needed"  b. The Braden Risk A 7/16/15 documented indicated a Risk Leve c. On 7/22/15 at 8:15 sitting up in the wheed d. On 7/22/15 at 8:20 the resident was sitting room. The resident was line of sight.  e. On 7/22/15 at 9:35 Assistant (CNA) #8 et CNA washed the changed her shirt. The check the resident for f. On 7/22/15 at 9:35 her self down the hal room area for activitied g. On 7/22/15 from 9 this Surveyor observer room playing bingo.  h. On 7/22/15 at 11:0 wheeled her self down around and went back | k for altered skin integrity r/t mobility and incontinent of experience any skin lence. Approaches Toilet d PRN, with peri-care and lition after each toileting lition after each litio | F 31                | 4  |         |                            |

|                          | OF DEFICIENCIES<br>F CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   | ` ′                 | E CONSTRUCTION  | (X3) DATE SURVEY COMPLETED |  |
|--------------------------|---|--|---------------------|---|----------------------------|--|
|                          |   | 045189   | B. WING             |   | C<br>07/27/2015            |  |
|                          | ROVIDER OR SUPPLIER   |  | s<br>9              | TREET ADDRESS, CITY, STATE, ZIP CODE  ON MAGNOLIA RD  CAMDEN, AR 71701                                      | 07/2//2015                 |  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIEN  | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY) | BE COMPLETION              |  |
| F 314                    | ithe dining room, in of Surveyor.  j. On 7/22/15 at 12:: propelling self in the CNA #8 was asked I be checked for incording the CNA stated, "Evasked when was the resident. The CNA stated, "Evasked, "What time distated, 10:30 a.m. The resident's room ther face and change her [for incontinence stated, "I didn't checked for incontinent was and returned with the gain and returned with the gain and returned with I. The resident was CNA #8 and #3 provinces and #3 provinces was well brief was saturated with the pants was well brief was saturated with the same surface and groin resident on her right to perform incontine the same surface of | mained in the wheelchair in constant observation of this 25 p.m., the resident was wheelchair down the hall. How often are the residents to nationace and repositioned. Wery 2 hours." The CNA was a last time you checked this stated she had checked the went to lunch. The CNA was id you go to lunch?" The CNA he CNA asked, "You were in at 9:30 a.m. and you washed and her shirt. Did you check at her time?" The CNA k her." The resident was nair from 8:15 until 12:25 p.m. irs and 15 minutes and was | F 314               |   |                            |  |

|                          | OF DEFICIENCIES CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   | 1 ' '               | E CONSTRUCTION   | (X3) DATE SURVEY COMPLETED |
|--------------------------|--|--|---------------------|--|----------------------------|
|                          |  | 045189   | B. WING             |  | C<br>07/27/2015            |
|                          | ROVIDER OR SUPPLIER  |  |                     | STREET ADDRESS, CITY, STATE, ZIP CODE 900 MAGNOLIA RD CAMDEN, AR 71701                                   | 1 07/2/1/2013              |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIEN   | TATEMENT OF DEFICIENCIES<br>CY MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY) | BE COMPLETION              |
| F 314                    | the same soiled glov clean incontinent bri they were finished w stated, "Yes." The C wipe the rectal area rectal area and a da cloth. The resident w before the cloth returned to the cloth returned t | ance on the cloth. Wearing res, the CNAs then applied a ef. The CNAs were asked if with the incontinent care and NAs were asked if they could again. CNA #3 wiped the rkish substance soiled the rkish substance soiled the ras wiped 3 more times rined free of feces.  diagnoses of Schizophrenia e Quarterly MDS with an ARD ted the resident scored 0 (0-7 inpaired) on the BIMS, stance of one person for bed is, extensive assistance of 1 hygiene, was incontinent of ind at risk for developing  comprehensive Care Plan ented, "Problem need, I tance with bed mobility, in, dressing, toileting, personal in Goal, I will not have further [Activity Daily Living] is, If I am incont. of B&B int. care and if I wear a brief is change. Please assist with whing and encourage me to PRN." Problem Need, I am allocers r/t incontinent of B&B ioal, I will not have any skin ches, Reposition me Q 2 H. | F 31-               |  |                            |
|                          | propelling the wheel   | chair down the East hall. At entered the resident's room   |                     |  |                            |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |  | (X2) MULTI<br>A. BUILDIN   | PLE CONSTRUCTION  G |   | (X3) DATE SURVEY<br>COMPLETED |                            |
|---|--|--|---------------------|---|-------------------------------|----------------------------|
|   |  | 045189   | B. WING _           |   |                               | C<br>07/27/2015            |
|   | ROVIDER OR SUPPLIER S HEALTH AND REHA  | BILITATION, LLC  |                     | STREET ADDRESS, CITY, STATE, ZIP CODE 900 MAGNOLIA RD CAMDEN, AR 71701                          | •                             | 0112112013                 |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIEN   | STATEMENT OF DEFICIENCIES<br>CY MUST BE PRECEDED BY FULL<br>R LSC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF COR<br>(EACH CORRECTIVE ACTION S<br>CROSS-REFERENCED TO THE A<br>DEFICIENCY) | SHOULD BE                     | (X5)<br>COMPLETION<br>DATE |
| F 314   | Continued From pag   | ge 71  | F 3                 | 14  |                               |                            |
|   | resident's hair. The in the wheelchair. To out of the room.  | ident's face and brushed the resident was not repositioned he resident wheeled himself   |                     |   |                               |                            |
|   | the wheelchair prop  | 88 a.m., the resident was in elling himself down the ent was observed by this  |                     |   |                               |                            |
|   | the resident was sitt  | 40 a.m., 9:30 a.m., 9:33 a.m., ing in the wheelchair without or checked for incontinence.  |                     |   |                               |                            |
|   | e. On 7/22/15 at 9:3 himself to the dining   | 33 a.m., the resident wheeled room for activities.   |                     |   |                               |                            |
|   |  | 9:33 a.m. through 11:00 a.m.,<br>the dining room at an activity  |                     |   |                               |                            |
|   | a.m., the resident w   | 11:00 a.m. through 12:15 as in the wheelchair in the being repositioned and ence.  |                     |   |                               |                            |
|   |  | :45 p.m., the resident was elf in a wheelchair down the  |                     |   |                               |                            |
|   | in the wheelchair in pushed the resident The CNA stated tha to get clean linen to p.m., the resident w bathroom. The resident from 8:20 a.m. until | 2 p.m., the resident was sitting the hallway and CNA #8 down the hall to his room. It she was waiting for the key change the resident. At 1:45 as taken to the resident's lent was in the wheelchair 1:45 p.m. without being oned, approximately 5 hours |                     |   |                               |                            |

|                          | OF DEFICIENCIES<br>CORRECTION   |  |                     | DATE SURVEY<br>COMPLETED  |          |                            |
|--------------------------|---|--|---------------------|---|----------|----------------------------|
|                          |   | 045189   | B. WING             |   |          | C                          |
|                          | ROVIDER OR SUPPLIER S HEALTH AND REHAE  |  |                     | STREET ADDRESS, CITY, STATE, ZIP CODE 900 MAGNOLIA RD CAMDEN, AR 71701                              | ·        | 07/27/2015                 |
| (X4) ID<br>PREFIX<br>TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  |  | ID<br>PREFI)<br>TAG | PROVIDER'S PLAN OF CORF<br>( (EACH CORRECTIVE ACTION S<br>CROSS-REFERENCED TO THE AF<br>DEFICIENCY) | HOULD BE | (X5)<br>COMPLETION<br>DATE |
| F 314                    | and 25 minutes. The with limited assistance incontinent brief was urine. CNA #8 provide peri-wash. The CNA penis 2 times with the in a back and forth modern the cleanse the resident.  3. On 7/23/15 at 2:4 Resident #2 and #4 vincontinence and we in the wheelchair the CNA stated, "No." Toften should the resident where incontinence and the up in the wheelchair. Hours." The CNA wensuring that the resident incontinence and being stated, "Skin breakded "What is the problem not cleansed of urine stated, "Skin breakded the resident's skin shouter. The CNA stated. | e resident was able to stand be. The resident's removed and saturated with ed the incontinent care with wiped across the top of the esame surface of the cloth action. The CNA did not is buttocks or inner thighs.  O p.m., CNA #8 was asked if were checked for the residents repositioned morning of 7/22/15. The the CNA was asked how | F3                  | 114   |          |                            |
| F 323<br>SS=K            | only plain water?" The the skin clean and skin skin clean and skin skin skin skin skin skin skin skin   | ne CNA stated, "Not getting<br>kin breakdown."<br>ACCIDENT<br>ISION/DEVICES  | F3                  | 23  |          |                            |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: |  | (X2) MULTII<br>A. BUILDIN   | PLE CONSTRUCTION  G |  | (X3) DATE SURVEY<br>COMPLETED |                            |  |
|--|--|---|---------------------|--|-------------------------------|----------------------------|--|
|  |  | 045189  | B. WING             |  |                               | C<br><b>07/27/2015</b>     |  |
|  | ROVIDER OR SUPPLIER  | BILITATION, LLC   |                     | STREET ADDRESS, CITY, STATE, ZIP CODE 900 MAGNOLIA RD CAMDEN, AR 71701                               |                               |                            |  |
| (X4) ID<br>PREFIX<br>TAG   |  |   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRE<br>(EACH CORRECTIVE ACTION SH<br>CROSS-REFERENCED TO THE APP<br>DEFICIENCY) | OULD BE                       | (X5)<br>COMPLETION<br>DATE |  |
| F 323  | Continued From pag   | ge 73   | F 3:                | 23   |                               |                            |  |
|  | by: Complaint #20365 ( all or in part. in these  A. Based on observinterview, the facility due to behaviors we promptly developed implemented and as ensure physician, A (resident guardian), involved in developing safety of resident as that were in close of staffing to monitor resinjury for 1 (Resident #13 and #14) case radmitted to the Cert the past 6 months. Immediate Jeopardy caused serious injur Resident #8 who sumaxillary fracture and 19 residents that residents that residents unit as Jeopardy was removat 7:00 a.m. and the "H" when the facility initiated corrective and correct the under time of the survey. The same same same same same same same sam | ration, record review and refailed to ensure risk factors and consistently assessed for effectiveness; to dult Protective Services and facility management and interventions to ensure a well as the other residents ontact; to ensure sufficient esident to prevent resident to t #7) of 4 (Resident #7, #12, mix residents who were affect Alzheimer Care Unit in This failed practice resulted in a which caused or could have by, harm or possible death for estained an orbital and and had the potential to affect asided on the Certified of 7/21/15. The Immediate wed by the facility on 7/21/15 ascope/severity reduced to identified the issue and ction however the facility did rlying deficient practice at the The facility was informed of ardy removed on 7/24/15 at |                     |  |                               |                            |  |

| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION |  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   | (X2) MULTIPLE CONSTRUCTION A. BUILDING |   | (X3                               | (X3) DATE SURVEY<br>COMPLETED |  |
|---|--|--|--|---|-----------------------------------|-------------------------------|--|
|   |  | 045189   | B. WING _                              |   |                                   | C<br><b>07/27/2015</b>        |  |
|   | ROVIDER OR SUPPLIER  | ABILITATION, LLC   |  | STREET ADDRESS, CITY, STATE, ZIP O<br>900 MAGNOLIA RD<br>CAMDEN, AR 71701 | CODE                              | 01/21/2010                    |  |
| (X4) ID<br>PREFIX<br>TAG                            | (EACH DEFICIE  | STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG                    | PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCE  | TION SHOULD BE<br>THE APPROPRIATE | (X5)<br>COMPLETION<br>DATE    |  |
| F 323   | 4/6/15 with diagno Behavioral Disturb and Insomnia.  The History and P geri-psych unit dat "Admit Date: 03/a psych unit in Litt and /or taking food Concern was expron an acute unit at facility, he has been beds and take their absolutely unavailatime" The Disc documented, "Pring behavioral disturbed Schizophrenia. The Patient arrived as due to confusion a as well as a tender clients at that Psychell he was at risk clients at that facility Hospital Course: Frand continued to exintrusiveness, and tendency to not take prompting Despit the patient remain intrusive and difficities began to have tole terms of side effect. | ses of Dementia with ance, Schizophrenia, Anxiety  hysical Report from the ed 3/13/15 documented, 13/2015He apparently was in the Rock and he was aggressive and from other people's trays? essed that he might be harmed and was sent to Geri unit. At this en noted to lay on other people or clothing. Any other history is able to this physician at this harge Summary dated 4/6/15 inciple Diagnosis: Dementia with ances Secondary Diagnoses are Reason for Hospitalization: a referral from (Hospital Name) and inability to care for himself ince to be so intrusive with other chiatric facility that staff there for being beaten as most of the ty were younger than the client. Patient was admitted to our unit evidence confusion, ease of agitation as well as a see his medication despite the increasing doses of Haldol ed, he is easily agitated and cult to redirect and eventually enability issues with the Haldol in ts" | F3                                     | 323   |                                   |                               |  |
|   |  | esident scored 3 (a score of 0-7 impaired) on the Brief Interview  |  |   |                                   |                               |  |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: |   | (X2) MULTIPL<br>A. BUILDING  | E CONSTRUCTION      |  | (X3) DATE SURVEY COMPLETED |                            |  |
|--|---|--|---------------------|--|----------------------------|----------------------------|--|
|  |   | 045189   | B. WING             |  | 07                         | C<br>/ <b>27/2015</b>      |  |
|  | ROVIDER OR SUPPLIER  S HEALTH AND REHA  | BILITATION, LLC  | ,                   | STREET ADDRESS, CITY, STATE, ZIP CODE<br>900 MAGNOLIA RD<br>CAMDEN, AR 71701                       | , <u>v</u>                 |                            |  |
| (X4) ID<br>PREFIX<br>TAG   |   |  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORR<br>(EACH CORRECTIVE ACTION SI<br>CROSS-REFERENCED TO THE AP<br>DEFICIENCY) | HOULD BE                   | (X5)<br>COMPLETION<br>DATE |  |
| F 323  | had wandering behave required limited ass mobility, transfers, a and personal hygier incontinent of bowel was 75 inches (6 for received Antipsychological Antianxiety medicat responsible party was Service) worker #1.  a. Departmental Nordocumented, "On 4/4 admitted to [facility In Unit LTC [long term independently in congait."  b. Departmental Nordays) documented to increased agitatic intrusiveness that remedication. The Dedocument consultat facility management risk of being injured behaviors:  1) Departmental Nordocumented, "Residoors. Resident entiand disturbing them redirected and diversion, pacing and exit so [milligrams] IM [intra- | IMS); had a mood score of 0; aviors that occurred daily; stance of 1 person for bed imbulation in room or corridor ne; was occasionally and bladder; had no pain; of 2 1/2 inches) in height; and tic, Antidepressant and fon 7 of the past 7 days. The las APS (Adult Protective)  The same of the past 7 days are as a part of the past 7 days. The las APS (Adult Protective)  The same of the past 7 days are as a part of the past 7 days. The las APS (Adult Protective)  The same of the past 7 days are as a part of the past 7 days. The las APS (Adult Protective)  The same of the past 7 days are as a part of the past 7 days. The las APS (Adult Protective)  The same of the past 7 days are as a part of the past 7 days. The last 1:12 a.m. and 1:12 a.m. are as a part of the past 1:12 a.m. are | F 323               |  |                            |                            |  |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION  A. BUILDING  A. BUILDING |   | · /   | (X3) DATE SURVEY COMPLETED |   |            |                            |
|--|---|---|----------------------------|---|------------|----------------------------|
|  |   | 045189  | B. WING                    |   | 0.7        | C<br><b>//27/2015</b>      |
|  | ROVIDER OR SUPPLIER   |   |                            | STREET ADDRESS, CITY, STATE, ZIP CODE  900 MAGNOLIA RD  CAMDEN, AR 71701                                | 01/21/2013 |                            |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIENC   | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG        | PROVIDER'S PLAN OF CORREC<br>(EACH CORRECTIVE ACTION SHO<br>CROSS-REFERENCED TO THE APPE<br>DEFICIENCY) | OULD BE    | (X5)<br>COMPLETION<br>DATE |
| F 323  | is becoming verbally other residents. He selse I will hold you in will be put in jail for repoints at a female redon't say a word or I medicated with Hald awake wandering ar soda from a female it down and he uses.  3) Departmental Nota.m. documented, "resident is up wander and telling female resay anything. Attempseat and he states resident wander with seated himself at tat IM right deltoid."  Departmental Notes documented, "New [Physician] derease mg at hs [hour of sle Zyprexa, give Seroq at hs APS [Adult"  4) Departmental Notes documented, "On 4/Resident went to state seated in her w/c [will did you get my chair present and states, turns to resident date. | B/15 at 3:00 p.mResident aggressive with staff and states, 'If you say anything a contempt of court and you no less than 9 days.' He sident states 'Sit down and will put you in jail.' Resident ol 5 mg IM. At 7:15 p.m. ound in dining room takes a resident she asks him to put profanity."  Bes dated 4/10/15 at 12:26  On 4/9/15 at 6:00 p.m. ering around the dining room sident to sit down and do not obts to redirect resident to his Stop talking' staff let a close supervision until he ole 6:30 p.mHaldol 5 mg  dated 4/10/15 at 3:06 p.m. or orders received from [decrease] Trazadone to 150  ep], dc [discontinue]  uel 25 mg. q a.m. and 50 mg  Protective Services] notified  es dated 4/11/15 at 1:01 a.m. 10/15 at 4:45 p.m. nd over female resident neelchair] and asks her 'Why resident daughter remains 'No that her w/c.' resident ghter and states, "You are a cross the hall for privacy | F 32                       | 23  |            |                            |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING A. BUILDING |   | (X3) DATE SURVEY<br>COMPLETED  |                     |  |                 |  |
|--|---|--|---------------------|--|-----------------|--|
|  |   | 045189   | B. WING             |  | C<br>07/27/2015 |  |
|  | ROVIDER OR SUPPLIER   |  |                     | STREET ADDRESS, CITY, STATE, ZIP CODE 900 MAGNOLIA RD CAMDEN, AR 71701                                 | 1 07/21/2013    |  |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIEN  | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY) | D BE COMPLETION |  |
| F 323  | a female room and r was redirected by st with redirection"  5) Departmental Not p.m. at 7:30 p.m. do pushed the west exi causing the alarm toHaldol 5 mg IM."  6) Departmental Not p.m. documented, "I verbally abusive to r Administered Loraze 2130 [9:30 p.m.]"  7) Departmental Not p.m. documented, "I hallways and other r various objects and Resident got hold of started pushing it do attempted to get car became combative, had better get away away from cart conti other resident belon agitated and verbally 1200 Lorazepam 1 r much difficulty."  8) Departmental Not documented, "4/22/turned to water on ir placed a trash can it to fill the sink overflot [number] bedroom verbally bedroom verbally and person to fill the sink overflot [number] bedroom verbally and person to since the sink overflot [number] bedroom verbally and person to sink the sink overflot [number] bedroom verbally and person to sink the sink overflot [number] bedroom verbally and person to sink the sink overflot [number] bedroom verbally and person to sink the sink overflot [number] bedroom verbally and person to sink the sink overflot [number] bedroom verbally and person to sink the sink overflot [number] bedroom verbally and person the sink overflot [number] and person [number] | ness. 7:30 p.m. Resident is in refuses to leave room. He aff after 15 minutes spent res dated 4/13/15 at 10:28 cumented, "resident to door open to the courtyard of sound. Resident redirected res dated 4/19/15 at 10:44 Resident up pacing hallway | F 323               | 3  |                 |  |

| AND BLAN OF CORRECTION IN IMPER |  | ` ′   | E CONSTRUCTION      | (X3) DATE SURVEY COMPLETED   |                 |  |
|---------------------------------|--|---|---------------------|--|-----------------|--|
|                                 |  | 045189  | B. WING             |  | C<br>07/27/2015 |  |
|                                 | ROVIDER OR SUPPLIER  | BILITATION, LLC   |                     | STREET ADDRESS, CITY, STATE, ZIP CODE  900 MAGNOLIA RD  CAMDEN, AR 71701                                 | 1 07/27/2013    |  |
| (X4) ID<br>PREFIX<br>TAG        | (EACH DEFICIENC  | TATEMENT OF DEFICIENCIES<br>CY MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY) | BE COMPLETION   |  |
| F 323                           | other itemshe the mealHe refused to aggressive with staff Haldol 5 mg IM right  Departmental Notes documented, "Resid door this morning, as when staff attempted [Physician] notified, Lorazepam 1 mg po [hours] prn agitation 3:34 p.m. documente facility on 4/30/15 ar adjustments.  9) Departmental Not at 11:00 a.m. documa gitated and started eye wash station. Hi knocking out a pane Resident medicated [right] arm for agitation 10) Departmental Not p.m. documented, "1 pacing the hallway b [agitation] noted to be refuses to go into dir 'there's bad people in given po at this time  11) Departmental Not a.m. documented, "1 back and forth in hal increase agitation with the staff pack and forth in hal increase agitation with the staff pack and forth in hal increase agitation with the staff pack and forth in hal increase agitation with the staff pack and forth in hal increase agitation with the staff pack and forth in hal increase agitation with the staff pack and forth in hal increase agitation with the staff pack and forth in hal increase agitation with the staff pack and forth in hal increase agitation with the staff pack and forth in hal increase agitation with the staff pack and forth in hal increase agitation with the staff pack and forth in hal increase agitation with the staff pack and forth in hal increase agitation with the staff pack and forth pack and for | walkers, trash cans, and an was served alternate eat became verbally. He was medicated with deltoid."  dated 4/23/15 at 2:54 p.m. ent followed staff out of exit gitated and slightly combative d to redirect him back new order received for [by mouth] q [every] 4 hrs" Departmental Notes at ed the physician would be at and make medication  es dated 4/26/15 at 1:39 p.m. ented, "Resident became to ambulate in hallway by the window with his right hand of plexi-glass. No injury. with Lorazepam 1 mg IM roon."  of the stated 4/29/15 at 12:37 (12:34 p.m. R [Resident] lack and forth. Agitstion the increased at this time. Robing room and eat, stating in there.' Lorazepam 1 mg Im there.' Lo | F 323               | 3  |                 |  |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING |   | COMPLETED  | . ,                 |  |               |                      |
|--|---|--|---------------------|--|---------------|----------------------|
|  |   | 045189   | B. WING             |  | 07/27/201     | 15                   |
|  | ROVIDER OR SUPPLIER   | ABILITATION, LLC   |                     | STREET ADDRESS, CITY, STATE, ZIP CODE  900 MAGNOLIA RD  CAMDEN, AR 71701                             | ,             |                      |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIE   | STATEMENT OF DEFICIENCIES<br>NCY MUST BE PRECEDED BY FULL<br>DR LSC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRE<br>(EACH CORRECTIVE ACTION SH<br>CROSS-REFERENCED TO THE APP<br>DEFICIENCY) | OULD BE COMPL | (5)<br>LETION<br>ATE |
| F 323  | Medication Adminis/1/15 - 5/31/15 (3) resident had 24 ep aggression, and/or PRN medication. To document consulta facility managements of being injure behaviors:  1) Departmental N documented, "At 1 and forth in hallwatrying to hit staff ar administered. At 1 pacing back and for [angry] balling fist residents. Lorazep  2) Departmental N documented, "at pacing back and for [angry], balling fist areas and for [angry], balling fist pacing back and for [angry], balling fist pacing back and for [angry], balling fist pacing back and for [angry], balling fist paging fist pacing back and for [angry], balling fist paging fist pacing back and for [angry], balling fist paging fi | otes and the May 2015 stration Record (MAR) from 1 days) documented the isodes of increased agitation, intrusiveness that required The Departmental Notes did not ation with physician, APS, or not regarding resident increased d or injuring others due to his  otes dated 5/2/15 at 10:59 p.m. 0:00 a.m. resident pacing back by, very anger, balling fist and and residents. Lorazepam 2 mg and trying to hit staff and am 2 mg administer[ed]"  otes dated 5/2/15 at 10:59 p.m. 1700 [5:00 p.m.] resident orth in hallway, very anger and trying to hit staff and am 2 mg administer[ed]" | F 32                |  |               |                      |
|  | the resident was a p.o. for increased a  4) The back of the the resident was a p.o. for increased a  5) Departmental N documented, "2:45  | May 2015 MAR documented dministered Lorazepam 1 mg agitation on 5/4/15 at 6:15 p.m.  May 2015 MAR documented dministered Lorazepam 1 mg agitation on 5/5/15 at 1030.  otes dated 5/6/15 at 3:54 a.m. is p.m. Resident up wandering redirected easily agitated.   |                     |  |               |                      |

PRINTED: 08/10/2015 FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY

| [ ` '                    |   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  | (X2) MULTIPLE CONSTRUCTION A. BUILDING |     |  | (X3) DATE SURVEY<br>COMPLETED |                            |
|--------------------------|---|---|--|-----|--|-------------------------------|----------------------------|
|                          |   | 045189  | B. WING                                |     |  |                               | 27/ <b>2015</b>            |
|                          | ROVIDER OR SUPPLIER S HEALTH AND REHAB  |   |  | 9   | STREET ADDRESS, CITY, STATE, ZIP CODE  00 MAGNOLIA RD  CAMDEN, AR 71701                                      | <u> </u>                      | 27/2013                    |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC   | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION)   | ID<br>PREF<br>TAG                      |     | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) |                               | (X5)<br>COMPLETION<br>DATE |
| F 323                    | Continued From page   | e 80<br>es dated 5/7/15 at 6:28 a.m.  | F                                      | 323 |  |                               |                            |
|                          | documented, "5:30 a. attempting to wander   |   |  |     |  |                               |                            |
|                          | documented, "0915 F<br>agitation at this time.<br>not leave things on he<br>noted trying to move<br>another R was leanin<br>noncompliant with red | es dated 5/7/15 at 1:02 p.m. R is noted to have extreme Housekeeper state he will er cart alone. R [Resident] the doghouse on the unit as g on it as he does daily. R direction. Lorazepam 2 t 0.5 ml (1 mg) IM given at" |  |     |  |                               |                            |
|                          | "1100 [11:00 a.m.]-R<br>his room in another R<br>on. R in other reside  | dated 5/7/15 at 1:16 p.m., is noted across the hall from a room without pants or brief nt's bathroom running the almost overflowing. R taken  |  |     |  |                               |                            |
|                          | documented, "Reside<br>down hallways. Inatte<br>knobs trying to open of<br>house trying to pick it  | es dated 5/8/15 at 12:08 a.m. ent up wandering up and ention fidgeting with door doors. Moving the dog up. Not easily redirected Ativan 1 mg 1 tablet given po  |  |     |  |                               |                            |
|                          | documented, "Reside<br>getting into drawers a<br>counter. Resident will<br>easily redirected to hi  | es dated 5/8/15 at 6:02 a.m. ent wandering in dining room and anything that is on the linot put on clothing and not s room. Increased agitation nim or redirect. Ativan 1 mg  |  |     |  |                               |                            |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION  A. BUILDING  A. BUILDING |  | (X3) DATE SURVEY COMPLETED  |                     |  |                 |  |
|--|--|---|---------------------|--|-----------------|--|
|  |  | 045189  | B. WING             |  | C<br>07/27/2015 |  |
|  | ROVIDER OR SUPPLIER  | BILITATION, LLC   | ,                   | STREET ADDRESS, CITY, STATE, ZIP CODE<br>900 MAGNOLIA RD<br>CAMDEN, AR 71701                             | 1 0/12/12013    |  |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIEN   | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY) | BE COMPLETION   |  |
| F 323  | Continued From pag   | ge 81   | F 323               | 3  |                 |  |
|  | at 11:59 a.m. documof resident's rooms of turning water on not noted to be incontine approached him for very resistive and be Male staff arrived and 12:30 Ativan 1 mg p. 11) The back of the the resident was adrip.o. for increased agonal p.o. for increa | May 2015 MAR documented ministered Lorazepam 1 mg pitation at 7:00 p.m. on 5/8/15.  Otes dated 5/8/15 at 4:44 a.m. of [p.m.] Resident up diaper on head and no directed increase in agitation esident go back to room. given po"  Otes dated 5/9/15 at 6:05 a.m. net [resident] taking clothes Resident as [has] clothing all er on head and shirt on the urinating outside door. Not evan 1 mg po given"  May 2015 MAR documented ministered Lorazepam 1 mg pitation at 7:00 p.m. on |                     |  |                 |  |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: |  | (X2) MULTI<br>A. BUILDIN  | PLE CONSTRUCTION  G |   | (X3) DATE SURVEY<br>COMPLETED |                            |
|--|--|---|---------------------|---|-------------------------------|----------------------------|
|  |  | 045189  | B. WING _           |   |                               | C<br>07/27/2015            |
|  | ROVIDER OR SUPPLIER S HEALTH AND REHA  | BILITATION, LLC   |                     | STREET ADDRESS, CITY, STATE, ZIP CODE 900 MAGNOLIA RD CAMDEN, AR 71701                            |                               | 0112112013                 |
| (X4) ID<br>PREFIX<br>TAG   | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)   |   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORF<br>(EACH CORRECTIVE ACTION S<br>CROSS-REFERENCED TO THE AF<br>DEFICIENCY) | HOULD BE                      | (X5)<br>COMPLETION<br>DATE |
| F 323  | F 323 Continued From page 82   |   | F 3                 | 23  |                               |                            |
|  |  | ues with behavior escalation.<br>h Ativan 1 mg 2 po"  |                     |   |                               |                            |
|  | the resident was ad  | May 2015 MAR documented ministered Lorazepam 1 mg gitation on 5/16/15 at 1940   |                     |   |                               |                            |
|  | the resident was ad  | May 2015 MAR documented ministered Lorazepam 1 mg gitation on 5/17/15 at 1610   |                     |   |                               |                            |
|  | p.m. documented, " observed standing a out at parking lot, he and needs to go ge window, multiple att away from window b became severely ag aggressive. At 10:3 Lorazepam 0.5 ml 1 resident became ex and unable to give a mg po given and tal | otes dated 5/21/15 at 4:04 1000 [10 a.m.] Resident at window in kitchen looking e said he see his car out there t it, he attempted to open empts per staff to divert him before he complied, then he gitated with staff and verbally 0 a.m. attempted to give mg IM per assist x 3 staff, tremely agitated and resistive complete dose Lorezpam 1 ken without incident" |                     |   |                               |                            |
|  | p.m. documented, "<br>with Ativan 1 mg 1 p   | otes dated 5/21/15 at 11:42<br>7:00 p.m. He is medicated<br>bo for increased agitation<br>to assist with changing of his  |                     |   |                               |                            |
|  | a.m. documented, " 0.5mg im [IM]for be [agitated] and trying resident froom [roor  | otes dated 5/22/15 at 6:43<br>1:10 a.m. gave bruse [?]<br>ing vety [very] aggitated<br>to take things in other<br>n]. " The May 2015<br>tration Record (MAR)  |                     |   |                               |                            |

|                          | OF DEFICIENCIES  CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  | ` ′                 | PLE CONSTRUCTION   | (X3) DATE SURVEY<br>COMPLETED |                            |
|--------------------------|---|---|---------------------|--|-------------------------------|----------------------------|
|                          |   | 045189  | B. WING             |  | 07/2                          |                            |
|                          | ROVIDER OR SUPPLIER   |   |                     | STREET ADDRESS, CITY, STATE, ZIP CODE 900 MAGNOLIA RD CAMDEN, AR 71701                                       | 0772                          | 7/2015                     |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIEN  | STATEMENT OF DEFICIENCIES<br>ICY MUST BE PRECEDED BY FULL<br>R LSC IDENTIFYING INFORMATION) | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTI<br>(EACH CORRECTIVE ACTION SHOUL<br>CROSS-REFERENCED TO THE APPRO<br>DEFICIENCY) | .D BE                         | (X5)<br>COMPLETION<br>DATE |
| F 323                    | a.m. documented, "observed at window window and trying to Resident left dining hallways and pound Nursing Station. Lor 22) Departmental Np.m. documented, resident has been presidents rooms and became agitated with Lorazepam 1 mg pour 23) Departmental Np.m. documented, pacing in the corridor wandering in other refroom #33] states he [Resident #7] back in Director of Nurses] [room #33] concerns his room. At 7:00 p. into room #34 when agitated states, 'Juresident sandwich a him with Ativan 1 m with resident [#7] ur room" |   | F 32                |  |                               |                            |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |   | (X2) MULTI<br>A. BUILDIN  | PLE CONSTRUCTION  G |   | (X3) DATE SURVEY COMPLETED |                            |  |
|---|---|---|---------------------|---|----------------------------|----------------------------|--|
|   |   | 045189  | B. WING _           |   |                            | C<br>07/27/2015            |  |
|   | ROVIDER OR SUPPLIER  S HEALTH AND REHAI   | BILITATION, LLC   |                     | STREET ADDRESS, CITY, STATE, ZIP CODE 900 MAGNOLIA RD CAMDEN, AR 71701                            |                            | 0112112010                 |  |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIEN  | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORF<br>(EACH CORRECTIVE ACTION S<br>CROSS-REFERENCED TO THE AF<br>DEFICIENCY) | HOULD BE                   | (X5)<br>COMPLETION<br>DATE |  |
| F 323   | Continued From pag  | je 84   | F 3                 | 23  |                            |                            |  |
|   | [Physician] with new  | I towards staff. Call placed to<br>orders received to increase<br>n am and 100 mg hs. [APS]<br>ss"  |                     |   |                            |                            |  |
|   |   | dated 5/28/15 at 4:34 p.m. ician] here to examine orders received."   |                     |   |                            |                            |  |
|   | to psych facility for A aggressively taking trays. Because of his felt that there might being placed in acut admitted to the Geria been reported that hother peoples' beds Beyond that, I can't seems to have done reduction on the metaking. At this point |   |                     |   |                            |                            |  |
|   | p.m. documented, "A<br>Lorazepam 2 mg IM<br>[agitation]."<br>d. Departmental Not<br>Medication Administ<br>6/1/15 - 6/30/15 (30<br>resident had 13 epis<br>aggression, and/or in<br>PRN medication. Th<br>document consultati                               | otes dated 5/31/15 at 4:10 At 4:15 p.m. administered right hip for agiation  es and the June 2015 ration Record (MAR) from days) documented the odes of increased agitation, intrusiveness that required e Departmental Notes did not on with physician, APS, or regarding resident increased |                     |   |                            |                            |  |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |   | (X2) MULTII<br>A. BUILDIN  | PLE CONSTRUCTION  G | (X3) DATE SURVEY<br>COMPLETED   |                   |
|---|---|--|---------------------|---|-------------------|
|   |   | 045189   | B. WING             |   | C<br>07/27/2015   |
|   | ROVIDER OR SUPPLIER  S HEALTH AND REHA  | BILITATION, LLC  |                     | STREET ADDRESS, CITY, STATE, ZIP CODE 900 MAGNOLIA RD CAMDEN, AR 71701                                  | 1 0772172010      |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIEN  | TATEMENT OF DEFICIENCIES<br>CY MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORREC<br>(EACH CORRECTIVE ACTION SHO<br>CROSS-REFERENCED TO THE APPI<br>DEFICIENCY) | OULD BE COMPLETIC |
| F 323   | behaviors:  1) Departmental Not documented, "At 14 in eyewash room, has smeared it on cabinarefused to change hassist him, he becare threatening. Lorazer 2) The back of the Junther resident was addressed as 3) The back of the Junther esident was add IM for behavior on 64) The back of the Junther esident was add IM for behavior agitatism.).  5) The back of the Junther resident was add IM for behavior agitatism.). | res dated 6/1/15 4:10 p.m. 30 [2:30 p.m.] Resident went ad BM [bowel movement] ets and is clothing. He is clothes or allow staff to ne verbally and physically | F 33                |   |                   |
|   | the resident was add  | une 2015 MAR documented<br>ministered Lorazepam 1 mg<br>gitation on 6/17/15 at 10:45   |                     |   |                   |
|   | the resident was add  | une 2015 MAR documented ministered Lorazepam 1 mg gitation on 6/19/15 at 4:30  |                     |   |                   |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |   | ` ′  | CONSTRUCTION   | (X3) DATE SURVEY COMPLETED C  |               |  |  |
|---|---|--|--|---|---------------|--|--|
|   |   | 045189   | B. WING  |   | 07/27/2015    |  |  |
|   | ROVIDER OR SUPPLIER  S HEALTH AND REHA  | ABILITATION, LLC   | STREET ADDRESS, CITY, STATE, ZIP CODE 900 MAGNOLIA RD CAMDEN, AR 71701 |   | 1 07/27/2013  |  |  |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIE   | STATEMENT OF DEFICIENCIES<br>NCY MUST BE PRECEDED BY FULL<br>OR LSC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG  | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROPR<br>DEFICIENCY) | BE COMPLETION |  |  |
| F 323   | 8) The back of the the resident was ad IM for behavior agif (10:02 p.m.).  9) The back of the the resident was ad p.o. for increased a a.m.  10) The back of the the resident was ad p.o. for increased a p.m.  11) The back of the the resident was ad p.o. for increased a p.m.  12) Departmental Nocumented, "4:20 pass staff he caugh around her left wris resident to released dining room for foo to be verbal aggres residents. He is mediated the resident was ad p.o. for increased a a.m.  13) The back of the the resident was ad p.o. for increased a a.m.  e. Departmental No Medication Adminis 7/1/15 - 7/16/15 (16) | June 2015 MAR documented deministered Lorazepam 1 mg tation on 6/21/15 at 2202  June 2015 MAR documented deministered Lorazepam 1 mg agitation on 6/23/15 at 10:45  June 2015 MAR documented deministered Lorazepam 1 mg agitation on 6/23/15 at 3:30  June 2015 MAR documented deministered Lorazepam 1 mg agitation on 6/23/15 at 3:30  June 2015 MAR documented deministered Lorazepam 1 mg agitation on 6/26/15 at 9:30  Notes dated 6/26/15 11:52 p.m. p.m. Resident was walking at her left arm holding tightly set, verbal cueing from staff to destaff arm then redirected to de and fluid. Resident continues assive to staff and other redicated with Ativan 1 mg po."  June 2015 MAR documented deministered Lorazepam 1 mg agitation on 6/27/15 at 11:40  June 2015 MAR documented deministered Lorazepam 1 mg agitation on 6/27/15 at 11:40  June 2015 MAR documented deministered Lorazepam 1 mg agitation on 6/27/15 at 11:40  June 2015 MAR documented deministered Lorazepam 1 mg agitation on 6/27/15 at 11:40 | F 323  |   |               |  |  |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER'SUPPLIER/CLIA IDENTIFICATION NUMBER: |  | 1 ' '   | E CONSTRUCTION      | (X3) DATE SURVEY COMPLETED  |                 |  |
|---|--|---|---------------------|---|-----------------|--|
|   |  | 045189  | B. WING             |   | C<br>07/27/2015 |  |
|   | ROVIDER OR SUPPLIER  | BILITATION, LLC   |                     | STREET ADDRESS, CITY, STATE, ZIP CODE<br>900 MAGNOLIA RD<br>CAMDEN, AR 71701                            | 1 07/21/2010    |  |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIEN   | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY) | BE COMPLETION   |  |
| F 323   | document consultati facility management risk of being injured behaviors:  1) The back of the Juthe resident was adr p.o. for increased aga.m.  2) Departmental Not documented, "10:30 resident observed on hallways, going in mothering them. Resmanic like mode with threatening towards divert his attention whave been futile"  3) The back of the Juthe resident was adr p.o. for increased aga.m.  4) The back of the Juthe resident was adr p.o. for increased aga.m.  6) Departmental Not documented, "10:48 morning in agitated aga.m. | e Departmental Notes did not on with physician, APS, regarding resident increased or injuring others due to his ally 2015 MAR documented ministered Lorazepam 1 mg pitation on 7/01/15 at 3:00 es dated 7/2/15 10:32 a.m. a.m. Ativan 1 mg po given, wer past hour pacing in ale residents room and ident talking non-stop in | F 323               |   |                 |  |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |  | (X2) MULTIF  | PLE CONSTRUCTION  3  |  | (X3) DATE SURVEY COMPLETED |                            |  |
|---|--|--|--|--|----------------------------|----------------------------|--|
|   |  | 045189   | B. WING  |  |                            | C<br><b>07/27/2015</b>     |  |
| NAME OF PROVIDER OR SUPPLIER  PINE HILLS HEALTH AND REHABILITATION, LLC                             |  |  | STREET ADDRESS, CITY, STATE, ZIP CODE  900 MAGNOLIA RD  CAMDEN, AR 71701 | 07/27/2013   |                            |                            |  |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIENC  | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG  | PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY) | HOULD BE                   | (X5)<br>COMPLETION<br>DATE |  |
| F 323   | f. The Resident's Correview date of 7/14/1 care) documented: "Problem Onset 04/1 aggressive behaviors episodes of verbally 50%. Approaches me and provide diverdocument my behavidated 4/26/15 document unit, with no  | t did not make contact.  | F 32   | 23   |                            |                            |  |
|   | needed] med before escalated."  "Problem Onset 04/1 [and]/or Behavior cor Psychotropic medica remain free of injury/ Psychotropic medica Approach Monit intervene as needed areas when behavior A handwritten note d [increased] verbal ag staff/residents D/C mg hs [decrease] Tra 25 mg am [and] 50 m  The care plan did not being injured or injuri | behaviors becomes  4/15Resident has Mood & neerns - Has orders for tion(s). GoalResident will adverse effects related to tion(s) for the next 30 days or for Behaviors andRemove to a private are disrupting to others "ated 4/10/15 documented, "gression towards [discontinue] Zyprexa 10 azodone 150 mg hs Seroquel ng pm"  t address resident's risk of ng others due to his intrusive viors. The care plan had no |  |  |                            |                            |  |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |   | (X2) MULTI<br>A. BUILDIN  | PLE CONSTRUCTION  G |   | (X3) DATE SURVEY COMPLETED |                            |  |
|---|---|---|---------------------|---|----------------------------|----------------------------|--|
|   |   | 045189  | B. WING _           |   |                            | C<br>07/27/2015            |  |
|   | ROVIDER OR SUPPLIER   | BILITATION, LLC   |                     | STREET ADDRESS, CITY, STATE, ZIP CODE 900 MAGNOLIA RD CAMDEN, AR 71701                              | - '                        | 0172172010                 |  |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIEN  | TATEMENT OF DEFICIENCIES<br>CY MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRI<br>(EACH CORRECTIVE ACTION SH<br>CROSS-REFERENCED TO THE AP<br>DEFICIENCY) | HOULD BE                   | (X5)<br>COMPLETION<br>DATE |  |
| F 323   | a.m. documented, "Nurse at Nurse's sta attacked me.' this n room and found [Re blood coming from r quarter sized swellin #8] could not state v [Resident #7] stated did resident hit her, kicked her in the fact this resident [Resident [Resident From End on pain scale 1-10. UE [upper extremition No noted blood on redivan 2 mg/ml 0.5 r mediusCalled on c6:55 a.m. Attempte and only answering Monitoring 1:1 form the facility began coresident at 6:30 a.m discharge.  Resident #8, a 102 y diagnosis of Alzheim Notes dated 7/21/15 resident was sent to (ER). Departmental a.m. documented, "from ER facial fractum maxillary fracture' during initial rounds right eye was swolle extensive dark purple left cheek area. The | tes dated 7/21/15 at 7:30 6:30 a.m. Resident came to attion stated, 'Someone curse followed resident to sident #8] sitting on bed with a sea and hematoma with a g to right eye. This [Resident what happened. Resident what happened. Resident a that happened. Resident a that happened. Resident did a that happened. Resident did and #8] hit him he stated, "No." and the resident into Nurses a sident #7] denies any pain 0 and LE [lower extremities] and LE | F3                  | 23  |                            |                            |  |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:                |  | 1 ' '   | PLE CONSTRUCTION  G |   | COMPLETED |                            |  |
|--|--|---|---------------------|---|-----------|----------------------------|--|
|  |  | 045189  | B. WING             |   |           | C<br>07/27/2045            |  |
| NAME OF PROVIDER OR SUPPLIER  PINE HILLS HEALTH AND REHABILITATION, LLC  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES |  |   |                     | STREET ADDRESS, CITY, STATE, ZIP CODE 900 MAGNOLIA RD CAMDEN, AR 71701                          | I         | 07/27/2015                 |  |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIEN   | STATEMENT OF DEFICIENCIES<br>ICY MUST BE PRECEDED BY FULL<br>R LSC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF COR<br>(EACH CORRECTIVE ACTION S<br>CROSS-REFERENCED TO THE A<br>DEFICIENCY) | SHOULD BE | (X5)<br>COMPLETION<br>DATE |  |
| F 323  | right nare.  The OLTC (Office of and Accident Report documented the typ taken to prevent conduring the investigal initiated immediately Enforcement and Ac [Resident #7] was revenue and the process of t | f Long Term Care) Incident to (I&A) dated 7/21/15 e of abuse Physical. Steps intinued Abuse or neglect tion: "An investigation was ay. Family, Local Law diministrator were notified. The emoved from room taken to realuation and placed 1:1 for a provided to Resident [#8] by RN) #1 and [Resident #8] was ansported to Ouachita County for evaluation. Investigation is ""  tes dated 7/23/15 at 3:14 p.m. ter's Care Unit Director d, "At approximately 1:30 at over the 1:1 continuous to CNA for lunch. [Resident #7] and down hallway. Resident to fitwo female residents and I string him to leave the room. Iternness and reverting to "coping to me. I attempted to hold the astrying to shut and he atting. 'I will murder you and nighing in the trees.' Once into hallway, resident ay agitated and inconsolable. To another resident's room, mable to redirect him out of #7] reached down to grab a the resident of the room he | F 3                 | 23  |           |                            |  |
|  | they will find you ha<br>redirected and back<br>became increasing!<br>He opened the dooi<br>entered and I was u<br>the room. [Resident<br>shoe belonging to the<br>entered and the two<br>aggressive towards   | nging in the trees.' Once into hallway, resident y agitated and inconsolable. to another resident's room, nable to redirect him out of #7] reached down to grab a   |                     |   |           |                            |  |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CL IDENTIFICATION NUMBER  |  | ` ′  | PLE CONSTRUCTION  G  | (X3) DATE SURVEY<br>COMPLETED |                            |  |  |
|--|--|--|--|-------------------------------|----------------------------|--|--|
|  | <b>045189</b> B. WING  |  |  |                               | C<br><b>07/27/2015</b>     |  |  |
| NAME OF PROVIDER OR SUPPLIER  PINE HILLS HEALTH AND REHABILITATION, LLC  |  | STREET ADDRESS, CITY, STATE, ZIP CODE 900 MAGNOLIA RD CAMDEN, AR 71701 |  | •                             |                            |  |  |
| (X4) ID SUMMARY STATEMENT OF DE PREFIX (EACH DEFICIENCY MUST BE PREC TAG REGULATORY OR LSC IDENTIFYING   | CEDED BY FULL  | ID<br>PREFIX<br>TAG  | PROVIDER'S PLAN OF CO<br>(EACH CORRECTIVE ACTION<br>CROSS-REFERENCED TO THE<br>DEFICIENCY) | N SHOULD BE<br>E APPROPRIATE  | (X5)<br>COMPLETION<br>DATE |  |  |
| F 323 Continued From page 91 ADON and [Name] DON entered to [DON] was able to get [Resident # walk him out the room. [Resident # increasingly agitated, would not ta Ativan 1 mg that the LPN was offer #7] became increasingly verbally to staff and several staff members sto "scared" of him at this point. He was be redirected and I sought guidant DON and ADON. I was told to call send him to ER. The ER was con ambulance was dispatched to the several staff members to get [Resident #7] was given Ativan 1 mg IM in right muscle. Phone [APS Worker #1] and message. ER call and stated they [Resident #7] back to the facility. It [APS Worker #1] and will seek plageri-psych. facility with her approved Departmental Notes dated 7/23/15 the resident was transferred out of p.m.  h. On 7/24/15 licensed nurses were At 9:40 a.m., Licensed Practical N was asked if she worked on the Control Notes asked what #7 behaviors. The LPN stated, "He in and out of other residents rooms trouble finding the bathroom. He he but I was able to control him better people. He got agitated, he would pick up things." The LPN was asked | 7] attention and #7] became ke the oral ring. [Resident hreatening to ated they were as not able to be from the ambulance and tacted and the facility. It took ident #7] to her. [Resident ght deltoid and left were sending spoke with becement at all of facility"  6 documented facility at 7:00  The interviewed:  The would wander is, he had and behaviors, in than other pace, pilfer and | F3   | 23   |                               |                            |  |  |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: |   | ` '  | PLE CONSTRUCTION  G  |   | (X3) DATE SURVEY<br>COMPLETED |                            |  |
|--|---|--|--|---|-------------------------------|----------------------------|--|
|  |   | 045189   | B. WING  |   |                               | C<br>07/27/204 <i>E</i>    |  |
|  | ROVIDER OR SUPPLIER   |  | STREET ADDRESS, CITY, STATE, ZIP CODE  900 MAGNOLIA RD  CAMDEN, AR 71701 |   | 07/27/2015                    |                            |  |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIEI  | STATEMENT OF DEFICIENCIES<br>NCY MUST BE PRECEDED BY FULL<br>R LSC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG  | PROVIDER'S PLAN OF CORREC<br>(EACH CORRECTIVE ACTION SHO<br>CROSS-REFERENCED TO THE APPI<br>DEFICIENCY) | OULD BE                       | (X5)<br>COMPLETION<br>DATE |  |
| F 323  | Then all of a sudder they had been rand she had talked to a CNAs reported to have asked if she have regarding the incression behaviors. The Lifthen Alzheimer Carasked what was the PRN [as needed stated, "We try rediwith him before we LPN was asked, "Ithe resident received days and the reside increased and was The LPN stated, "Not the Certified Alzeron CNAS reported to the suddent the resident received and the resident received | uld have to be medicated. In his behaviors escalated, Iom." The LPN was asked if Inyone. The LPN stated the Iversity is a reported to anyone else Iversity is a resident of the responsible party notified." | F 3:   | 23  |                               |                            |  |
|  | can become verbal redirect him." The behaviors the resid "Verbal threats that to you. Sometimes sometimes he requidown." The LPN widd the resident mahit. The LPN was sidocumented on 5/2 did ball up his fist a residents." The LP reported this incide "I can't remember." had called the Physical services in the called the presidents.   | The LPN stated, "At times he ly abusive and you have to LPN was asked what kind of ent exhibited. The LPN stated, he was going to do something he would calm down and ired medication to calm him as asked what kind of threats ke, did the resident threaten to hown documentation that she width of the LPN stated, "Yes he and threaten to hit staff and N was asked if she had int to anyone. The LPN stated, The LPN was asked if she sician or the responsibility party ased behaviors. The LPN  |  |   |                               |                            |  |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |  | , ,   | E CONSTRUCTION   | COMPLETED  |                        |  |
|---|--|---|--|--|------------------------|--|
|   |  | 045189  | B. WING  |  | C<br><b>07/27/2015</b> |  |
|   | ROVIDER OR SUPPLIER  | ABILITATION, LLC  | STREET ADDRESS, CITY, STATE, ZIP CODE 900 MAGNOLIA RD CAMDEN, AR 71701 |  | 0112112013             |  |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIEI   | STATEMENT OF DEFICIENCIES<br>NCY MUST BE PRECEDED BY FULL<br>R LSC IDENTIFYING INFORMATION)                                     | ID<br>PREFIX<br>TAG  | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY) | BE COMPLETION          |  |
| F 323   | "Do you feel that the behaviors should he LPN stated, "I protocall." The LPN was documented. The Lead ocumented. The residents were at rist that time, we redire medication." The lead ocumented in the lead ocumented. The resident be admitted unit with a Psychia stated, "No." The Lead ocumented in the lead ocumented in the lead ocumented. The lead ocumented in the lead ocumented. The lead ocumented in the lead ocumen | ermber." The LPN was asked, e resident's aggressive ave been reported?" The bably called the Supervisor on asked where this was | F 323  |  |                        |  |

| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION |  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  |                   |     | CONSTRUCTION   | (X3) DATE SURVEY<br>COMPLETED |                            |
|---|--|---|-------------------|-----|--|-------------------------------|----------------------------|
|   |  |   | A. BOILD          | NG  |  | ، ا                           | C                          |
|   |  | 045189  | B. WING           |     |  | 1                             | 27/2015                    |
| NAME OF P   | ROVIDER OR SUPPLIER  | •   | •                 | ST  | REET ADDRESS, CITY, STATE, ZIP CODE  |                               |                            |
| PINE HII I  | LS HEALTH AND REH  | ARII ITATION I I C  |                   | 90  | 0 MAGNOLIA RD  |                               |                            |
|   | TO TIERETTI AND RETI   | ABILITATION, ELG  |                   | CA  | AMDEN, AR 71701  |                               |                            |
| (X4) ID<br>PREFIX<br>TAG                            | (EACH DEFICIE  | STATEMENT OF DEFICIENCIES<br>NCY MUST BE PRECEDED BY FULL<br>OR LSC IDENTIFYING INFORMATION)  | ID<br>PREF<br>TAG |     | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BI<br>CROSS-REFERENCED TO THE APPROPRIA<br>DEFICIENCY) |                               | (X5)<br>COMPLETION<br>DATE |
| F 323   | ER [Emergency Rocame to the Nursir any signs or symplet [Resident #7] what stated 'I kicked he asked when did this occurred at about LPN was asked if the behaviors problem to resident contact behavior that was was asked where was asked where was asked where was asked how the stated, "The Chelping the other Cowas asked how the stated, "They have on the front and or was off the unit." Nursing Station." could see down the front hall where [Rocated." The LPN had any behaviors generally didn't was he get up at night Resident #7 had a stated, "He did was sleeping, but that romain the LPN was asked unit only has 1 CN the front hall and 1 residents. The LPN i. On 7/23/15, Cerinterviewed:  At 7:50 p.m., CNA: | g Station he was not showing toms of aggression. I asked happened. [Resident #7] are in the face." The LPN was a happen. The LPN stated, "It 6:30 a.m. on 7/21/15." The there had been any aggressive s. The LPN stated no resident, but he had aggressive at easily redirected. The LPN was a Certified Nursing then this incident occurred. The CNA was on the back unit CNA with a resident. The LPN are and the CNA on the back. The CNA are LPN stated, "I was at the The LPN was asked if she are hall. The LPN stated, "Not the desident #7 and #8] were I was asked if [Resident #8]. The LPN stated, "She ander, once in a blue moon did." The LPN was asked if my behaviors at night. The LPN ander at night, he had started morning he was getting up." and regarding the staffing, the A at night, for 18 residents on CNA on the back unit for 9 | F                 | 323 |  |                               |                            |

| URVEY<br>ETED              |
|----------------------------|
|                            |
| 7/2015                     |
|                            |
|                            |
|                            |
| (X5)<br>COMPLETION<br>DATE |
|                            |
|                            |

| STATEMENT OF DEFICIENCIES (X1 AND PLAN OF CORRECTION |  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   | (X2) MULTIPL<br>A. BUILDING | E CONSTRUCTION   | (X3) DATE SURVEY<br>COMPLETED |  |  |
|--|--|--|-----------------------------|--|-------------------------------|--|--|
|  |  | 045189   | B. WING                     |  | C<br>07/27/2015               |  |  |
|  | NAME OF PROVIDER OR SUPPLIER  PINE HILLS HEALTH AND REHABILITATION, LLC  |  |                             | STREET ADDRESS, CITY, STATE, ZIP CODE<br>900 MAGNOLIA RD<br>CAMDEN, AR 71701                               | •                             |  |  |
| (X4) ID<br>PREFIX<br>TAG                             | (EACH DEFICIEN   | STATEMENT OF DEFICIENCIES<br>ICY MUST BE PRECEDED BY FULL<br>R LSC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG         | PROVIDER'S PLAN OF CORRECT<br>(EACH CORRECTIVE ACTION SHOU<br>CROSS-REFERENCED TO THE APPRO<br>DEFICIENCY) | LD BE COMPLETION              |  |  |
| F 323  | asked if she had ca<br>stated, "Yes, togeth  | training yet." The CNA was<br>red for Resident #7. The CNA<br>er with the other CNA's." The  | F 323                       | 3  |                               |  |  |
|  | The CNA stated, "H<br>got real agitated. He<br>him. He would talk I<br>give him care. He w<br>working. He would w<br>atch him, he would<br>resident's room. He<br>towards staff." The<br>resident triedy to hit<br>When asked if the r   | out the resident's behaviors. It behaviors had slipped, he edidn't like people bothering like a cop. He wouldn't let us was in a mind that he was walk all the time. We had to d go in and out of other would get aggressive CNA was asked if the let staff. The CNA stated, "Yes." esident got aggressive the CNA stated, "No." |                             |  |                               |  |  |
|  | (DON) was asked a documentation regaresident was appropriately aware of his history documentation at the DON was asked if seriodent's aggressive the resident's clinical was aware of his paresident room. I was behaviors towards a DON was shown the that the resident has threatening the staff DON stated, "I was asked if the resident aggressive behavior DON stated, "No." Tresident is having in | arding Resident #7 if this<br>oriate for the Certified<br>ne DON stated, "I was not  |                             |  |                               |  |  |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: |   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   | (X2) MULT<br>A. BUILDI | FIPLE CONSTRUCTION  NG   |                              | (X3) DATE S<br>COMPLE |                            |  |
|--|---|--|------------------------|--|------------------------------|-----------------------|----------------------------|--|
|  |   | 045189   | B. WING _              |  |                              | 07/2                  | 7/2015                     |  |
|  | ROVIDER OR SUPPLIER S HEALTH AND REHAE  | BILITATION, LLC  |                        | STREET ADDRESS, CITY, STATE, ZIP CODE 900 MAGNOLIA RD CAMDEN, AR 71701                     |                              |                       | , 0,,2,,20,10              |  |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIENC   | TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)  | ID<br>PREFI<br>TAG     | PROVIDER'S PLAN OF C<br>X (EACH CORRECTIVE ACTIVE<br>CROSS-REFERENCED TO THE<br>DEFICIENCY | ON SHOULD BE<br>HE APPROPRIA |                       | (X5)<br>COMPLETION<br>DATE |  |
| F 323  | would put the other runit at risk. The DON  k. On 7/24/15 at 2:15 Unit Director (ACUD) aggressive behaviors regarding Resident # The ACUD was aske behaviors that requir should they report to should report to the N The ACUD was aske responsible party sho stated, "Yes. I though when the incident oc ACUD was asked wa responsible party not increased behaviors. had not notified the r worker #1] until 7/23, what was the importa Physician of the resid The ACUD stated, "F resident." The ACUI oversight on her part trying to transfer the was asked if she had responsible party wh the resident. The AC have called for guida if a resident with Psy Schizophrenia be ad | DN was asked if the of aggressive behaviors esidents on the Alzheimer's a stated, "Yes."  If p.m., the Alzheimer Care of if the staff reported any is or increased behaviors or increased behaviors. The ACUD stated, "No." of if a resident had increased ed to be medicated who if the Physician and bould be notified. The ACUD on the had been notified curred on 7/21/15. The inside the had been stated that she is the Physician and office when Resident #7 had if the ACUD stated that she is the Physician and office when Resident #7 had if the ACUD stated that she is the Physician and office when Resident #7 had if the ACUD stated that she is the Physician and office when Resident #7 had if the ACUD was asked ance of notifying the dent increased behaviors. For the benefit of the increased behaviors or the benefit of the increased that this was an increased that this was an increased that the physician or the en she was trying to transfer UD stated, "No, I should note." The ACUD was asked chiatric diagnosis, mitted to the Certified ACUD stated, "I would say | F                      | 323  |                              |                       |                            |  |
|  |   | p.m., the Administrator was documentation on a letter  |                        |  |                              |                       |                            |  |

| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION |  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   | (X2) MULTIPLE CONSTRUCTION  A. BUILDING |       |   | (X3) DATE SURVEY<br>COMPLETED |                            |
|---|--|--|---|-------|---|-------------------------------|----------------------------|
|   |  |  | A. BOILD                                | NG    | <del></del>   | , ا                           | С                          |
|   |  | 045189   | B. WING                                 |       |   |                               | 27/2015                    |
|   | ROVIDER OR SUPPLIER  S HEALTH AND REHA   | ABILITATION, LLC   | •                                       | 900 1 | EET ADDRESS, CITY, STATE, ZIP CODE<br>MAGNOLIA RD<br>MDEN, AR 71701   |                               |                            |
| (X4) ID<br>PREFIX<br>TAG                            | (EACH DEFICIE  | STATEMENT OF DEFICIENCIES<br>NCY MUST BE PRECEDED BY FULL<br>OR LSC IDENTIFYING INFORMATION)   | ID<br>PREFI<br>TAG                      |       | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD B<br>CROSS-REFERENCED TO THE APPROPRIA<br>DEFICIENCY) |                               | (X5)<br>COMPLETION<br>DATE |
| F 323   | and attached to the Care) Incident and dated 7/21/15. The had contacted [Phyfor [Resident #7]. Ithe resident had not aggressive behaviorery remorseful for has repeatedly ask ok?" The letter state to review this information resident from being geri-psych admission asked if the Reside given orders for the stated, "No." The Astaff had reported documented inciderecord of aggressival Administrator state was asked regardiletter referring to the diagnosis of Alzhei #7] had diagnosis Administrator state asked if she had rendered in the documented in record of aggressival asked if she had rendered in the documented in record of aggressivated, "No."  m. On 7/27/15 at 6 physician [Physician stated, "No." | 5, signed by the Administrator, e OLTC (Office of Long Term Accident Report (I&A) form Administrator stated that they ysician #1] to place a referral The documentation stated that of displayed any s/s of or at this time and that he was the events that took place and sed staff, "How is she? Is she sted [Physician #1] has agreed mation in attempt to prevent g placed outside the facility in on. The Administrator was ent's attending Physician had a referral. The Administrator diministrator was asked if the to her the frequently ent in the resident's clinical | F                                       | 323   |   |                               |                            |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  |   | A. BUILDING                               |   |  | (X3) DATE SURVEY COMPLETED  |  |  |
|--|---|---|---|--|---|--|--|
|  | 045189  | B. WING_                                  |   |  | C<br><b>07/27/2015</b>  |  |  |
|  | SILITATION, LLC   |   | STREET ADDRESS, CITY, STATE, ZIP CO<br>900 MAGNOLIA RD<br>CAMDEN, AR 71701  | DE   | 0112112013  |  |  |
| (EACH DEFICIENC  | CY MUST BE PRECEDED BY FULL   | ID<br>PREFIX<br>TAG                       | (EACH CORRECTIVE ACTIO<br>CROSS-REFERENCED TO TH  | N SHOULD BE<br>E APPROPRIAT  | (X5)<br>COMPLETION<br>DATE  |  |  |
| the physician stated,  n. On 7/24/15 at 3:40 Services (APS) Case Resident #7 was in A Caseworker stated, " was asked if had was resident to resident a Resident #7 and the was advised 7/23/15 hospital staff after I re was advised by [Alzh then afterwards. Onl hospital called By [7/21/15] he kicked a [Resident #8] I found Emergency Room Judge signed. [Cour Started process for tr out Thursday." The if aware of other beh measures have been the APS Caseworker about meds and we o behaviors sooner." asked if notified of th behaviors that includ female resident. The have not been notifie aggressive or hitting the incident yesterda nurse [Emergency R that incident sooner I arrangements to sen any aggressive beha  o. On 7/24/15 4:37 p | "Yes"  In p.m., Adult Protective eworker #1 was asked if APS custody and the Yes." The APS Caseworker is notified on 7/21/15 of any altercation that involved Caseworker stated, "No. I by Emergency Room eceived a call from them. I reimer's Care Unit] Director by received call after the the way on Tuesday 102 year old resident that out after he went to the I did an order to transport. The APS Caseworker was asked avior incidents could any intaken with Resident #7 and intaken | F3  | 23  |  |   |  |  |
|  |   |   |   |  |   |  |  |
|  | ROVIDER OR SUPPLIER  SHEALTH AND REHAE  SUMMARY ST (EACH DEFICIENC REGULATORY OR  Continued From page the physician stated,  n. On 7/24/15 at 3:40 Services (APS) Case Resident #7 was in A Caseworker stated, " was asked if had was resident to resident at Resident #7 and the was advised 7/23/15 hospital staff after I re was advised by [Alzh then afterwards. Onl hospital called By [7/21/15] he kicked a [Resident #8] I found Emergency Room Judge signed. [Cour Started process for tr out Thursday." The A if aware of other beh measures have been the APS Caseworker about meds and we de behaviors sooner." asked if notified of th behaviors that includ female resident. The have not been notified aggressive or hitting the incident yesterda nurse [Emergency R that incident sooner I arrangements to sen any aggressive beha  o. On 7/24/15 4:37 p Nurses (ADON) was   | CORRECTION IDENTIFICATION NUMBER:  045189 | ROVIDER OR SUPPLIER  SHEALTH AND REHABILITATION, LLC  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 99 the physician stated, "Yes"  n. On 7/24/15 at 3:40 p.m., Adult Protective Services (APS) Caseworker #1 was asked if Resident #7 was in APS custody and the Caseworker stated, "Yes" The APS Caseworker was asked if had was notified on 7/21/15 of any resident to resident altercation that involved Resident #7 and the Caseworker stated, "No. I was advised 7/23/15 by Emergency Room hospital staff after I received a call from them. I was advised by [Alzheimer's Care Unit] Director then afterwards. Only received call after the hospital called By the way on Tuesday [7/21/15] he kicked a 102 year old resident [Resident #8] I found that out after he went to the Emergency Room I did an order to transport. Judge signed. [County] Sheriff office transport. Started process for transport as soon as found out Thursday." The APS Caseworker was asked if aware of other behavior incidents could any measures have been taken with Resident #7 and the APS Caseworker #1 stated, "Talked to doctor about meds and we could have addressed the behaviors sooner." The APS Caseworker was asked if notified of the resident's increased behaviors that included hitting window and hitting female resident. The APS Caseworker stated, "I have not been notified about him getting aggressive or hitting objects. Found out about the incident yesterday when I was called by staff nurse [Emergency Room]. If I had known about that incident sooner I could have initiated arrangements to send out sooner. Not notified of any aggressive behavior."  o. On 7/24/15 4:37 p.m., the Assistant Director of Nurses (ADON) was asked, "How do you | ROUIDER OR SUPPLIER  S HEALTH AND REHABILITATION, LLC  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 99 the physician stated, "Yes"  n. On 7/24/15 at 3:40 p.m., Adult Protective Services (APS) Caseworker #1 was asked if Resident #7 was in APS custody and the Caseworker stated, "Yes" The APS Caseworker stated, "No. I was advised 7/23/15 by Emergency Room Inospital staff after I received a call from them. I was advised by [Alzheimer's Care Unit] Director then afterwards. Only received call after the hospital called By the way on Tuesday [7/21/15] he kicked a 102 year old resident [Resident #7] from them. I was advised y. The APS Caseworker was asked if aware of other behavior incidents could any measures have been taken with Resident #7 and the APS Caseworker was asked if aware of other behavior incidents could any measures have been taken with Resident #7 and the APS Caseworker stated, "The APS Caseworker was asked if notified of the residents increased behaviors that incided hitting window and hitting female resident. The APS Caseworker was asked if notified of the resident's increased behaviors that incided about him getting aggressive or hitting objects. Found out about that incident yesterday when I was called by staff nurse [Emergency Room]. If I had known about that incident yesterday when I was called by staff nurse [Emergency Room]. If I had known about that incident sooner I could have initiated arrangements to send out sooner. Not notified of any aggressive behavior."  o. On 7/24/15 4:37 p.m., the Assistant Director of Nurses (ADON) was asked, "How do you | A BUILDING  045189  A BUILDING  8. WING  STREET ADDRESS, CITY, STATE, ZIP CODE  900 MAGNOLIA RD  CAMDEN, AR 71701  SUMMARY STATEMENT OF DESCIGENCIES  (EACH DEPECTIONEY) MUST BE PRECEDED BY PILL  REQUILATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 99  the physician stated, "Yes"  n. On 7/24/15 at 3:40 p.m., Adult Protective  Services (APS) Caseworker #1 was asked if  Resident #7 was in APS custody and the  Caseworker stated, "Yes."  n. A provided of the resident involved  Resident #7 and the Caseworker stated, "No. I  was advised 7/23/15 by Emergency Room  hospital staff after I received a call from them. I  was advised by [Alzheimer's Care Unit] Director  then afterwards. Only received call after the hospital called By the way on Tuesday  (7/21/15) he kicked a 102 year old resident  Resident #3 floon that out after he went to the  Emergency Room I did an order to transport.  Judge signed. [County] Sheriff office transport.  Started process for transport as soon as found  out Thursday." The APS Caseworker was asked if  floware of other behavior incidents could any  measures have been taken with Resident #7 and  the APS Caseworker #1 stated, "Talked to doctor  about meds and we could have addressed the  behaviors sooner." The APS Caseworker was asked if nother behavior incidents could any  measures have been taken with Resident #7 and the  the APS Caseworker #1 stated, "Talked to doctor  about meds and we could have addressed the  behaviors sooner." The APS Caseworker was asked if nother behavior incidents could any  measures have been taken with Resident #7 and the  the APS Caseworker was asked in the many providence of the resident's increased  behaviors sooner. The APS Caseworker was asked in the providence of the resident's increased  behaviors sooner. The APS Caseworker was asked in the providence of the resident's increased  behaviors sooner. The APS Caseworker was asked in the providence of the resident's increased  behaviors sooner. The APS Caseworker was asked in the providence of |  |  |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: |  | ` '  | PLE CONSTRUCTION  G | COMPLETED   |                 |  |
|---|--|--|---------------------|---|-----------------|--|
|   |  | 045189   | B. WING             |   | C<br>07/27/2015 |  |
|   | ROVIDER OR SUPPLIER  | ABILITATION, LLC   |                     | STREET ADDRESS, CITY, STATE, ZIP CODE 900 MAGNOLIA RD CAMDEN, AR 71701  | 07/27/2015      |  |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIE  | STATEMENT OF DEFICIENCIES<br>NCY MUST BE PRECEDED BY FULL<br>IR LSC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTIC<br>(EACH CORRECTIVE ACTION SHOULI<br>CROSS-REFERENCED TO THE APPROF<br>DEFICIENCY) | O BE COMPLETION |  |
| F 323   | was staffed accord staffing ratio. The Adocumentation in the with the ratios for the staff to 8 residents evening and night. The ADON stated,  Complaint #20365 with these findings:  B. Based on observinterview, the facility were not lifted and axillae during trans wheelchair for 1 (R #4, and #6) case-mobelt transfer and 9 #8, #9, #10, and #7 required assistance wheelchair. The fatto affect 7 residents transfers on the Ealist provided on 7/2 (DON) and 14 resided pendent on the ER Rounds of 7/21/15.  Resident #6 had di Chorea, Type 2 Dia Anemia, and Anxie Data (MDS) with an of 6/12/15 docume indicates severely if or Mental Status (Iphysical assistance not steady with ball | it?" The ADON stated that unit ing to the state minimum ADON was shown the he Alzheimer Unit Care Book he primary care givers as 1 on the day shift and the ratio is 1 staff to 10 residents. "I've never seen that before."  (AR00018476) substantiated in the residents repositioned underneath the fer and repositioning in a resident #6) of 3 (Residents #3, hix residents who required gait (Resident #1, #2, #3, #4, #6, 11) case mix residents who required gait (Resident #1, #2, #3, #4, #6, 11) case mix residents who required gait (Resident #1, #2, #3, #4, #6, 11) case mix residents who required gait (Resident #1, #2, #3, #4, #6, 11) case mix residents who required gait (Resident #1, #2, #3, #4, #6, 11) case mix residents who required gait (Resident #1, #2, #3, #4, #6, 11) case mix residents who required gait (Resident #1, #2, #3, #4, #6, 11) case mix residents who required gait (Resident #1, #2, #3, #4, #6, 11) case mix residents who required gait (Resident #1, #2, #3, #4, #6, 11) case mix residents who required gait (Resident #1, #2, #3, #4, #6, 11) case mix residents who required gait (Resident #1, #2, #3, #4, #6, 11) case mix residents who required gait (Resident #1, #2, #3, #4, #6, 11) case mix residents who required gait (Resident #1, #2, #3, #4, #6, 11) case mix residents who required gait (Resident #1, #2, #3, #4, #6, 11) case mix residents who required gait (Resident #1, #2, #3, #4, #6, 11) case mix residents who required gait (Resident #1, #2, #3, #4, #6, 11) case mix residents who required gait (Resident #1, #2, #3, #4, #6, 11) case mix residents who required gait (Resident #1, #2, #3, #4, #6, 11) case mix residents who required gait (Resident #1, #2, #3, #4, #6, 11) case mix residents who required gait (Resident #1, #2, #3, #4, #6, 11) case mix residents who required gait (Resident #1, #2, #3, #4, #6, 11) case mix residents who required gait (Resident #1, #2, #3, #4, #6, #1) case mix residents who required gait (Resident #1, #2, #3, #4, #6, #1) case mix residents who required gait (Resident #1, #2, #3, #4, # | F 32                | 23  |                 |  |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: |  | (X2) MULTI<br>A. BUILDIN  | PLE CONSTRUCTION  G | (X3) DATE SURVEY<br>COMPLETED   |         |                            |
|--|--|---|---------------------|---|---------|----------------------------|
|  |  | 045189  | B. WING             |   | 07/2    | 7/2015                     |
|  | ROVIDER OR SUPPLIER  S HEALTH AND REHA   | BILITATION, LLC   |                     | STREET ADDRESS, CITY, STATE, ZIP CODE 900 MAGNOLIA RD CAMDEN, AR 71701                                  | 1 0112  |                            |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIENCY MUST BE PRECEDED BY FULL  |   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORREC<br>(EACH CORRECTIVE ACTION SHO<br>CROSS-REFERENCED TO THE APPE<br>DEFICIENCY) | OULD BE | (X5)<br>COMPLETION<br>DATE |
| F 323  | a. The Care Plan da am at risk for falls r/sudden movements Skid sock" There indicated the type o required for transfer b. The Lift/Mobility Adated 6/9/14 and sig Nurse (LPN) #9, do Lift/Transfer Assess Resident stand, pivous assistance or with li with no risk of falling Yes Comments/susection "Partial Lift response was not or questions listed in the "Is Resident able to at least 1 leg? Can Physical Assistance simple directions? Is trength with ability Is Resident able to at least 1 leg? Can Physical Assistance simple directions? Is trength with ability Is Resident able to a mid to lower back? questions are YES-Stand LiftTotal Lift tolerate being in a so These areas were resident as a superior of the care o | eelchair; and had 2 or more ated 6/15/15 documented, "I (t [related to] uncontrollable or/t Huntington's Chorea was no documentation that f assistance the resident | F 3.                | 23  |         |                            |
|  | pericare, the resident LPN #4 on the resident  | 10 a.m., after receiving<br>nt sat up on the bedside with<br>lent's right side. LPN #4<br>erneath the resident's right  |                     |   |         |                            |

| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION |  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   | (X2) MULTIPLE CONSTRUCTION  A. BUILDING |     | (X3) DATE SURVEY<br>COMPLETED  |   |                            |
|---|--|--|---|-----|--|---|----------------------------|
|   |  |  | A. BOILD                                |     |  | С |                            |
|   |  | 045189   | B. WING                                 |     |  | l | 27/2015                    |
|   | ROVIDER OR SUPPLIER  S HEALTH AND REHA   | ABILITATION, LLC   |   | 900 | REET ADDRESS, CITY, STATE, ZIP CODE<br>O MAGNOLIA RD<br>AMDEN, AR 71701  |   |                            |
| (X4) ID<br>PREFIX<br>TAG                            | (EACH DEFICIE  | STATEMENT OF DEFICIENCIES<br>NCY MUST BE PRECEDED BY FULL<br>R LSC IDENTIFYING INFORMATION)  | ID<br>PREFI<br>TAG                      |     | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BI<br>CROSS-REFERENCED TO THE APPROPRIA<br>DEFICIENCY) |   | (X5)<br>COMPLETION<br>DATE |
| F 323   | placed her hand an arm. The LPNs phyresident up from sit bedside then took at to sit down. The resident from the 11:15 a.m., the resist the wheelchair from the 11:15 a.m., the resist the wheelchair in the hassistant (CNA) #7 wheelchair and CN side. CNA #7 lifted right arm and grasp the hip area. CNA the resident's axilla resident up in the waresident upright in the pushed the wheelch 11:18 a.m. At 11:20 to the edge of the whofacing the resident placed her left arm axilla. The Business to the resident's rigwith her right arm un axilla, the 2 staff mount upward to reposition wheelchair. At 11:20 fixin' to slide out ag resident's right side are sident's right side underneath each of lifted up on the shoresident in the wheelch in the w | at the resident's left side and ound the resident's upper left ysically lifted the barefoot ting position to stand at the a few steps to the wheelchair sident had spastic movements .PN #4 pushed the resident's eroom down the hallway. At dent slid down to the edge of the LPN stopped the allway and Certified Nursing was on the right side of the A #8 joined her on the left underneath the resident's ped the resident's pants over #8 placed an arm underneath and lifted upwards to pull the wheelchair to reposition the the wheelchair to reposition the he wheelchair with his buttocks on eelchair seat. LPN #4 stood on the resident's left side and underneath the resident's left as Office Manager (BOM) went have the side of the wheelchair and underneath the resident's right embers lifted the resident and anderneath the resident and underneath the resident and the BOM went to the and each put their arm of the resident's axillae and unders to resposition the | F                                       | 323 |  |   |                            |

|                          |  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  | (X2) MULT<br>A. BUILDIN | IPLE CONSTRUCTION  IG  | (X3) DATE SURVEY<br>COMPLETED |                            |  |
|--------------------------|--|---|-------------------------|--|-------------------------------|----------------------------|--|
|                          |  | 045189  | B. WING _               |  |                               | C<br>07/27/2015            |  |
|                          | ROVIDER OR SUPPLIER S HEALTH AND REHA  | BILITATION, LLC   | ,                       | STREET ADDRESS, CITY, STATE, ZIP CODE<br>900 MAGNOLIA RD<br>CAMDEN, AR 71701                     | 1 3772772313                  |                            |  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIEN   | STATEMENT OF DEFICIENCIES<br>ICY MUST BE PRECEDED BY FULL<br>R LSC IDENTIFYING INFORMATION)   | ID<br>PREFI)<br>TAG     | PROVIDER'S PLAN OF CORRECT ( (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY) | OULD BE                       | (X5)<br>COMPLETION<br>DATE |  |
| F 323                    | and the LPN stated. The LPN was asked belt for transfer and won't let us use the was asked if the resused for transfer an he has full use of his him just guiding him was appropriate and different case."  e. On 7/23/15 at 4:0 what type of transfer the LPN stated, "Gaif a gait belt had been was transferred to the tated, "No." LPN # transferred the resident his hand." The should have been un "Probably." The LP the resident for trans "Me." After review of LPN was shown the 4:58 p.m. if there was for the transfer/lift as it."  f. On 7/27/15 at 4:3 (DON) was asked if transfers should be the DON stated, "No could occur from this can cause bruising in the sake of the transfer should be the DON stated, "No could occur from this can cause bruising in the sake of the transfer should be the DON stated, "No could occur from this can cause bruising in the sake of the transfer should be the DON stated, "No could occur from this can cause bruising in the policy of the transfer should be the DON stated, "No could occur from this can cause bruising in the policy of th | ge 103 In does the resident require In "He's a 2 person assist." If if the resident needed a gait It the LPN stated, "He really Igait belt on him." The LPN Isident should have a gait belt Id the LPN stated, "He helps, Is legs so we're not pulling on In." The LPN was asked if that Id the LPN stated, "He's a  Is p.m., LPN #9 was asked In did the resident require and Inti belt." The LPN was asked In used when the resident Interesident and the LPN Is was asked how she had Ident and the LPN stated, "I Is LPN was asked if a gait belt Is sed and the LPN stated, In was asked who assessed Is a safer and the LPN stated, If the Transfer Assessment the Is assessment and asked at It as a completed assessment Ind the LPN stated, "No that's  In p.m., the Director of Nursing In residents who were gait belt Is lifted under the axillae and In The DON was asked what Is and the DON stated, "You Is and shoulder dislocation." | F3                      | 23   |                               |                            |  |
|                          | non-nursing staff sh   | ould lift and reposition selchair and the DON stated,   |                         |  |                               |                            |  |

| STATEMENT OF DEFICIENCIES (X1) PROVIDE IDENTIFIC   |  | A. BUILDIN          | IG  | (X3) DATE SURVEY COMPLETED  |  |  |
|--|--|---------------------|---|---|--|--|
|  | 045189   | B. WING _           |   |   | C<br>07/27/2015  |  |
|  | BILITATION, LLC  |                     | STREET ADDRESS, CITY, STATE, ZIP<br>900 MAGNOLIA RD<br>CAMDEN, AR 71701   | CODE  |  |  |
| (EACH DEFICIEN   | CY MUST BE PRECEDED BY FULL  | ID<br>PREFIX<br>TAG | ( (EACH CORRECTIVE AC<br>CROSS-REFERENCED TO  | TION SHOULD B<br>THE APPROPRIA  |  |  |
| The DON was ld not lift or repostated, "Not tractly and they could be so only on the second of the s | asked why non-nursing staff osition residents and the sined to position them ould cause injury."  OF MEDICATION ERROR MORE   |                     |   |   |  |  |
| aplaint #20354 (<br>r in part) on the ad on observation on 7/21/15 and on 7/22/15, recty failed to ensuress than 5% to olications for 3 (residents observes resulting in residents were made by 1), (LPN #3 and rived administer failed practice hents who reside ved medication es according to cotor of Nursing (cation error rate inistration of 49 rived. The finding  | AR00018459) substantiated se findings: on of the 4:00 p.m. medication the 8:00 a.m. medication cord review and interview, the re the medication error rate prevent potential Residents #4, #9, and #10) and during the medication enedication errors. Medication electron decidents are prevented to a licensed practical nurses with a potential to affect 32 and the potential to affect 32 and on the East Hall and a sadministered from these a list provided by the DON) on 7/23/15. The are was 8.16% based on medications with 4 errors angs are: |                     |   |   |  |  |
|  | SUMMARY S (EACH DEFICIENCE REGULATORY OR RECEIVED AND AND AND AND AND AND AND AND AND AN   |                     | ROR SUPPLIER  ILTH AND REHABILITATION, LLC  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  The DON was asked why non-nursing staff Identifier or reposition residents and the stated, "Not trained to position them scitly and they could cause injury."  25(m)(1) FREE OF MEDICATION ERROR ES OF 5% OR MORE  facility must ensure that it is free of cation error rates of five percent or greater.  REQUIREMENT is not met as evidenced in plaint #20354 (AR00018459) substantiated r in part) on these findings:  and on observation of the 4:00 p.m. medication on 7/21/15 and the 8:00 a.m. medication on 7/22/15, record review and interview, the sy failed to ensure the medication error rate less than 5% to prevent potential plications for 3 (Residents #4, #9, and #10) residents observed during the medication errors. Medication so were made by 2 Licensed Practical Nurses (1), (LPN #3 and #4), of 2 licensed nurses rived administering medications in the facility. failed practice had the potential to affect 32 ents who resided on the East Hall and ved medications administered from these es according to a list provided by the stor of Nursing (DON) on 7/23/15. The cation error rate was 8.16% based on nistration of 49 medications with 4 errors rived. The findings are: | R OR SUPPLIER  LITH AND REHABILITATION, LLC  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  The DON was asked why non-nursing staff Id not lift or reposition them citly and they could cause injury."  25(m)(1) FREE OF MEDICATION ERROR ES OF 5% OR MORE  facility must ensure that it is free of cation error rates of five percent or greater.  REQUIREMENT is not met as evidenced in plaint #20354 (AR00018459) substantiated rin part) on these findings:  and on observation of the 4:00 p.m. medication on 7/21/15 and the 8:00 a.m. medication on 7/21/15, record review and interview, the yf alied to ensure the medication error rate less than 5% to prevent potential plications for 3 (Residents #4, #9, and #10) residents observed during the medication errors. Medication swere made by 2 Licensed Practical Nurses (), (LPN #3 and #4), of 2 licensed nurses rived administering medications in the facility. failed practice had the potential to affect 32 ents who resided on the East Hall and ved medications administered from these es according to a list provided by the cor of Nursing (DON) on 7/23/15. The cation error rate was 8.16% based on nistration of 49 medications with 4 errors rived. The findings are: | R OR SUPPLIER  LTH AND REHABILITATION, LLC  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  The DON was asked why non-nursing staff ld nol lift or reposition residents and the stated, "Not trained to position them citty and they could cause injury."  25(m)(1) FREE OF MEDICATION ERROR  25 OF 5% OR MORE  lacility must ensure that it is free of cation error rates of five percent or greater.  REQUIREMENT is not met as evidenced in part) on these findings:  In part) on the 4:00 p.m. medication on 7/21/15 and the 8:00 a.m. medication on 7/21/15 and the 8:00 a.m. medication on 7/21/15 and the 8:00 a.m. medication error rate less than 5% to prevent potential bicitations for 3 (Residents #4, #9, and #10) residents observed during the medication es resulting in medication error. Medication es resulting in medication error in the facility, lailed practice had the potential to affect 32 ents who resided on the East Hall and wed medications administerized from these es according to a list provided by the tor of Nursing (DON) on 7/23/15. The cation error rate was 8.16% based on nistration of 49 medications with 4 errors rived. The findings are: |  |

| STATEMENT OF DEFICIENCIES  AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: |   | 1 ' '  | E CONSTRUCTION      | (X3) DATE SURVEY COMPLETED C  |               |  |
|---|---|--|---------------------|---|---------------|--|
|   |   | 045189   | B. WING             |   | 07/27/2015    |  |
|   | ROVIDER OR SUPPLIER   | ABILITATION, LLC   |                     | STREET ADDRESS, CITY, STATE, ZIP CODE<br>900 MAGNOLIA RD<br>CAMDEN, AR 71701                            | 1 0/12/12013  |  |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIE   | STATEMENT OF DEFICIENCIES<br>NCY MUST BE PRECEDED BY FULL<br>IR LSC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY) | BE COMPLETION |  |
| F 332   | a. A physician orde "Metformin Hcl [hyd [milligrams] tablet 1 (crush)."  b. On 7/21/15 at 4 Metformin 1000 mg approximately one-administered it to the amount of water. The bedside table. At 4 nurses station, got cookie with cream resident's bedside bedside table and in the cookie. The LF room and did not with food provided. The tresident had be a the LPN stated, "Not she always eats it." had stayed and obe eaten the cookie at what you mean." | ed, Alzheimer's Disease, and ccident (CVA).  If dated 1/13/14 documented, drochloride]1000 mg I PO [by mouth] with food  I Sa4 p.m., LPN #3 crushed the grablet and mixed it in thalf teaspoon of jelly, then ne resident with a small here was no other food on the safety and safety and laid the cookie on the and laid the cookie on the nstructed the resident to eat PN promptly left the resident ate The dietary department meal to be served until 5:15 p.m. for the LPN was asked if she served that the resident had not the LPN stated, "No, I see | F 33:               |   |               |  |
|   | Fracture, Subdural Deficiency, and Sc   | r dated 4/12/13 documented,<br>  Vit [vitamin] D 200 tablet 1  |                     |   |               |  |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |   | 1 ' '   | (X2) MULTIPLE CONSTRUCTION  A. BUILDING |     |   | (X3) DATE SURVEY<br>COMPLETED |         |
|---|---|---|---|-----|---|-------------------------------|---------|
|   |   | 045189  | B. WING _                               |     |   | C<br>07/27/2015               |         |
|   | ROVIDER OR SUPPLIER S HEALTH AND REHAB  | ILITATION, LLC  |   | 90  | TREET ADDRESS, CITY, STATE, ZIP CODE<br>00 MAGNOLIA RD<br>AMDEN, AR 71701   | 1 011                         | 2772010 |
| (X4) ID<br>PREFIX<br>TAG  | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)              |   | ID<br>PREFI)<br>TAG                     | <   | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD B<br>CROSS-REFERENCED TO THE APPROPRIA<br>DEFICIENCY) | SHOULD BE                     |         |
| F 332   | Continued From page   | e 106   | F3                                      | 332 |   |                               |         |
|   | Calcium 600 with Vita<br>ounces of water and<br>service did not begin   | p.m., LPN #3 administered amin D with approximately 2 no food. The evening meal until 5:15 p.m.   |   |     |   |                               |         |
|   |   | onvulsions, General Muscle  |   |     |   |                               |         |
|   |   | dated 9/27/13 documented,<br>et give 1 tab PO QD [every   |   |     |   |                               |         |
|   | 8:00 a.m. medication:<br>Folic Acid tablet, whic<br>8:00 a.m. medication<br>medication card for F                                   | m., LPN #4 administered the s, but did not administer the ch was scheduled with the pass. At 3:55 p.m., the olic Acid 1 mg had a tablet ication card for the 22nd.  |   |     |   |                               |         |
|   |   | dated 9/27/13 documented,<br>elay 64 mg tablet 1 tablet<br>."   |   |     |   |                               |         |
| F 441   | Magnesium Oxide 40 instead of Mag Delay p.m., LPN #4 was asl ordered and the LPN The LPN was asked LPN looked at the bo Oxide 400." | m., LPN #4 administered 0 mg tablet to the resident 64 mg as ordered. At 3:00 ked what medication was stated, "Mag 64 one tablet." what was given, after the ttle, stated, "I gave him Mag CONTROL, PREVENT | FZ                                      | 141 |   |                               |         |
| SS=F  |   | blish and maintain an<br>gram designed to provide a   |   |     |   |                               |         |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |  | 1 ' '  | LE CONSTRUCTION     | (X3) DATE SURVEY COMPLETED  |                 |  |
|---|--|--|---------------------|---|-----------------|--|
|   |  | 045189   | B. WING             |   | C<br>07/27/2015 |  |
|   | ROVIDER OR SUPPLIER  S HEALTH AND REHA   | BILITATION, LLC  |                     | STREET ADDRESS, CITY, STATE, ZIP CODE  900 MAGNOLIA RD  CAMDEN, AR 71701                                |                 |  |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIEN   | TATEMENT OF DEFICIENCIES<br>CY MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY) | BE COMPLETION   |  |
| F 441   | to help prevent the confidence of disease and infection for disease from direct contact will train for disease from disease from direct contact will train for disease from direct contact will train for disease from direct contact will train for di | promfortable environment and development and transmission tion.  Program ablish an Infection Control th it - trols, and prevents infections occurred, such as isolation, an individual resident; and rd of incidents and corrective fections.  and of Infection on Control Program sident needs isolation to of infection, the facility must prohibit employees with a asse or infected skin lesions with residents or their food, if ansmit the disease. Trequire staff to wash their ect resident contact for which icated by accepted ect.  dle, store, process and is to prevent the spread of | F 44                | 1   |                 |  |
|   | by:<br>Complaint #20354 (  | T is not met as evidenced  AR00018459) was in part) in these findings:   |                     |   |                 |  |

|                          | OF DEFICIENCIES<br>CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  | (X2) MULT<br>A. BUILDII | TIPLE CONSTRUCTION  NG   | _   | (X3) DATE<br>COMP | SURVEY<br>LETED            |
|--------------------------|--|---|-------------------------|--|---|-------------------|----------------------------|
|                          |  | 045189  | B. WING _               |  |   |                   | 27/ <b>2015</b>            |
|                          | ROVIDER OR SUPPLIER  | BILITATION, LLC   |                         | STREET ADDRESS, CITY, S<br>900 MAGNOLIA RD<br>CAMDEN, AR 71701 | STATE, ZIP CODE   | 1 011             | 2772010                    |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC  | TATEMENT OF DEFICIENCIES<br>BY MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION)   | ID<br>PREFII<br>TAG     | X (EACH CORR   | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) |                   | (X5)<br>COMPLETION<br>DATE |
| F 441                    | their hands between prevent the potential (Residents #1, #2, #4 (Residents #1 thru #4 residents who require of daily living.  The facility failed to eand gowns before erfollowed contact isolate to prevent potential seridents for 1 of 1 (If resident who require precautions and universidents for 1 of 1 (If the facility failed to eat the facility failed to eat the facility failed the facility failed the facility failed to eat the facility failed to e | n, record review and failed to ensure staff washed dirty and clean tasks to spread of infection for 6 4, #6, #9, and #11) of 12 4 and #6 thru #13) case mix ed assistance with activities ensure staff donned gloves attering an isolation room and ation precaution procedures apread of infection to other Resident #1) case mix d contact isolation rersal precautions to prevent affection for 4 (Resident #1, 2 (Residents #1 thru #4 and x residents who received ice y thermos and the | F                       | 141  |   |                   |                            |
|                          | residents' medication contaminated hands or illness for 3 of 3 (Figure 2 (Residents #9 and had blood glucose m These failed practice 32 residents on the E   | ensure staff avoided touching in containers with to prevent potential infection Residents #1, #9, and #11) who received medications call Nurse (LPN) #3.  ensure a blood glucose differ use to prevent infection for 1 (Resident #9) of #11) case mix residents who conitor checks.   |                         |  |   |                   |                            |

|                          | OF DEFICIENCIES<br>CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   | (X2) MULT<br>A. BUILDIN | IPLE CONSTRUCTION  IG  |           | DATE SURVEY<br>COMPLETED   |
|--------------------------|--|--|-------------------------|--|-----------|----------------------------|
|                          |  | 045189   | B. WING _               |  |           | C<br>07/27/2015            |
|                          | ROVIDER OR SUPPLIER  | BILITATION, LLC  |                         | STREET ADDRESS, CITY, STATE, ZIP CODE 900 MAGNOLIA RD CAMDEN, AR 71701                   |           | 0112112013                 |
| (X4) ID<br>PREFIX<br>TAG |  |  | ID<br>PREFIX<br>TAG     | PROVIDER'S PLAN OF COR ( (EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY) | SHOULD BE | (X5)<br>COMPLETION<br>DATE |
| F 441                    | 7/21/15, 8 resident used, as document Director of Nursing required isolation, pand 27 residents what and had ice water is provided by the Ass (ADON) on 8/10/15. The findings are:  1. The facility polic Handwashing received at 11:10 a.m. and the Handwashing received documented, "Handwashing received coumented, "Handwashing received at 11:20 a.m. and the Handwashing received coumented, "Handwashing received coumented, "Handwashing received at 11:40 a.m. and the Handwashing received at 10 a.m. Handwashing received at infection contains a sinfected pacentaminated with spatients. 4. Betwee antisepsis is required for patients on contains a sinfection contains a sinfetion contains a sinfeti | Nurse (LPN) on Initial Rounds is who had glucose monitors and on a list provided by the (DON); 1 resident who wer Initial Rounds on 7/21/15; no resided on the East Wingwerved according to a list distant Director of Nursing of titled Housekeeping Routine wed from the DON on 7/22/15 are facility policy titled Routine wed at 11:25 a.m. on 7/22/15, alwashing is the single most preventing the spread of ashing indications (Patient contact with particularly is 3. After contact with a to be contaminated with a sisms or hospital pathogens, tient or an object or device secretions or excretions of en patients6. Hand and before leaving the room | F 4                     | 41   |           |                            |

|                          | OF DEFICIENCIES<br>CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  | (X2) MULT<br>A. BUILDIN | PLE CONSTRUCTION  IG  | , ,  | ATE SURVEY<br>OMPLETED |
|--------------------------|---|---|-------------------------|---|--|------------------------|
|                          |   | 045189  | B. WING _               |   |  | C<br><b>07/27/2015</b> |
|                          | ROVIDER OR SUPPLIER   |   |                         | STREET ADDRESS, CITY, STATE, ZIP COD<br>900 MAGNOLIA RD<br>CAMDEN, AR 71701 | •  | 07/27/2013             |
| (X4) ID<br>PREFIX<br>TAG |   |   | ID<br>PREFIX<br>TAG     | (EACH CORRECTIVE ACTION   | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |                        |
| F 441                    | isolation instructions believe that a reside communicable disea obtains a physician's Infection Control Nu implementing isolation response delay. 3. initiated:Explain to the isolation precautions until no Information Isolation certain infected resid disease to other resvisitors."  3. A procedure titled from he DON at 10:8 documented, "Multip MRSA, VRE [Vanco other bacteria resist. Gown yes, soiling is touching infective murine and possible secretions, and possantimicrobials cultur antimicrobials cultur antimicrobials cultur contained"  4. A procedure titled Room Cleaning recefrom the DON docur room 1) Scrub hand disinfectant soap. 2 1st-Booties 2nd-Cap 5th-Gloves Enter the and place in an isola property Additional | physician for appropriate when there is reason to ant has an infectious or ase. 2. The charge nurse is order for isolation; the rise or designee can approve on in the vent of physician Isolation Precautions are to thestaff the reason(s), for itons. Maintain isolation Ionger indicated. General in precautions are required for dents to prevent the spread of idents, employees, and id Infection Control received as a.m. on 7/22/15 ole-resistant organisms: mycin Resistant Enterococci]; ant to penicillin Mask No, likely; Gloves Yes for aterial; Infective Material afeces, infected area, pus, sibly feces; Duration Until | F 4                     | 41  |  |                        |

|                          | DF DEFICIENCIES<br>CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   | ` '                 | PLE CONSTRUCTION  IG  |                                | TE SURVEY<br>MPLETED       |
|--------------------------|--|--|---------------------|---|--------------------------------|----------------------------|
|                          |  | 045189   | B. WING _           |   |                                | C<br>7/27/2015             |
|                          | ROVIDER OR SUPPLIER S HEALTH AND REHAL   |  |                     | STREET ADDRESS, CITY, STATE, ZIP CO<br>900 MAGNOLIA RD<br>CAMDEN, AR 71701    |                                | 1/12/12015                 |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIEN   | TATEMENT OF DEFICIENCIES<br>CY MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY | ON SHOULD BE<br>IE APPROPRIATE | (X5)<br>COMPLETION<br>DATE |
| F 441                    | Continued From pag   | ge 111   | F4                  | 41  |                                |                            |
|                          | some type of commis to prevent the spricleaning-refer to the bacteria at a low lev area. Use a system protect the facility fromade to keep the base.  5. Resident #1 had Methicillin-Resistant (MRSA), Peripheral Pressure Ulcer, Gar Knee, and Amputative Admission Minimum Assessment Refered documented the resindicates moderately Interview for Mental to total dependence living, and had MRS.  a. The Care Plan darequire isolation due | Staphylococcus Aureus Vascular Disease, Stage 4 Igrene, Amputation Below on Above Knee. The Data Set (MDS) with an ince Date of 7/16/15 Ident had scored 11 (8-12 I impaired) on the Brief Status (BIMS), had extensive on staff for activities of daily A infection.  ated 7/21/15 documented, "I |                     |   |                                |                            |
|                          | rounds, the resident that identified the roa small cart located hallway that had suppaper gowns, red ba Licensed Practical N "Contact isolation foot. On 7/21/15 at 11.  | and a sign on the room door om as isolation and there was outside the room in the oplies that included yellow ags, and gloves on the cart. Iurse (LPN) #10 stated, r MRSA wound."  |                     |   |                                |                            |
|                          | the resident's bedsic  | s room, and LPN #8 stood at<br>de in the isolation room and<br>gloved. At 11:47 a.m., the  |                     |   |                                |                            |

|                          | OF DEFICIENCIES<br>CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  | (X2) MULT<br>A. BUILDIN | IPLE CONSTRUCTION  IG   |           | DATE SURVEY<br>COMPLETED   |
|--------------------------|--|---|-------------------------|---|-----------|----------------------------|
|                          |  | 045189  | B. WING                 |   |           | C<br>07/27/2015            |
|                          | ROVIDER OR SUPPLIER S HEALTH AND REHAL   |   |                         | STREET ADDRESS, CITY, STATE, ZIP CODE 900 MAGNOLIA RD CAMDEN, AR 71701                        | •         | 0112112013                 |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIEN   | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG     | PROVIDER'S PLAN OF COF<br>( (EACH CORRECTIVE ACTION<br>CROSS-REFERENCED TO THE<br>DEFICIENCY) | SHOULD BE | (X5)<br>COMPLETION<br>DATE |
| F 441                    | resident's face with a leaned her scrub top resident's bed railing across her chest. At the nebulizer mask at the left hand then for the LPN left the resident sanitizing her hand the hallway.  d. On 7/21/15 at 11: a gown, mask, and gresident's room. At a came out of the isola plastic trash bag with housekeeping cart, a bag into the large clear plastic trash bag with housekeeping cart, pushed the houseke stopped outside of Face washing or sanitizing mop to go into Resident so gloved scrub top against the scrub suit touching a removed the nebuliz then went into the bahands. The LPN did resident's room and | bulizer mask that was on the ungloved fingers as she and pants against the pants again with ungloved fingers of ded her arms. At 11:55 a.m., dent's room without washing ds then pushed a cart down  50 a.m., Housekeeper #1 put ploves on and entered the ploves on and the isolation items into the ploves on the | F4                      | 41  |           |                            |
|                          | f. On 7/21/15 at 4:5   | 8 p.m., the door was opened   |                         |   |           |                            |

| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION |   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   | ` ′                | (X2) MULTIPLE CONSTRUCTION  A. BUILDING |   | (X3) DATE SURVEY<br>COMPLETED |                            |
|---|---|--|--------------------|---|---|-------------------------------|----------------------------|
|   |   | 045189   | B. WING _          |   |   |                               | C<br>/ <b>27/2015</b>      |
|   | ROVIDER OR SUPPLIER   | BILITATION, LLC  |                    | STREET ADD<br>900 MAGNO<br>CAMDEN,      |   |                               | 12112013                   |
| (X4) ID<br>PREFIX<br>TAG                            | (EACH DEFICIEN  | STATEMENT OF DEFICIENCIES<br>ICY MUST BE PRECEDED BY FULL<br>R LSC IDENTIFYING INFORMATION)  | ID<br>PREFI<br>TAG |   | PROVIDER'S PLAN OF CORREC'<br>(EACH CORRECTIVE ACTION SHOU<br>CROSS-REFERENCED TO THE APPR<br>DEFICIENCY) | ULD BE                        | (X5)<br>COMPLETION<br>DATE |
| F 441   | during medication pisolation gown or glagainst the bed rail bed rail. The LPN amedication. At 5:00 bedside without wathen went to the medication cart the books. The Lart keys from her smedication cart draitouched the medication card frotablet. The LPN looplaced the keys in the LPN fisolation gown and cart, picked up the list water into a cup and to another area on administered pain in 5:05 p.m., the LPN room, and pushed the lallway to the door washing her hands.  G. On 7/22/15 at 8: Assistant (CNA) #7 without donning a gimeal tray out of the the tray to the metal opening the door wher hands. At 8:19 isolation room without went to the bedside | went into the isolation room leass without donning an loves. The LPN leaned leand her scrub top touched the leadministered the resident's leaning or sanitizing her hands, ledication cart in the doorway, letion Administration Record led narcotic books, then wrote lean removed the medication lecrub top pocket, unlocked the leaver and narcotic lock box, letion cards, then removed a lean the drawer and dispensed a leked the narcotic lock box and lethe top pocket of her scrub top. leaved the medication leaves went back inside the leaves bedside, without donning an leaves, back to the medication learge water pitcher, poured lead moved the glucose monitor leaves to the resident. At left the bedside, exited the leaves the medication cart down the l | F                  | 41                                      |   |                               |                            |

|                          | OF DEFICIENCIES<br>CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   | (X2) MULT<br>A. BUILDII | IPLE CONSTRUCT                            | ΓΙΟΝ  | (X3) DATE<br>COMP | SURVEY<br>PLETED           |
|--------------------------|--|--|-------------------------|---|---|-------------------|----------------------------|
|                          |  | 045189   | B. WING                 |   |   | 1                 | C<br><b>27/2015</b>        |
|                          | ROVIDER OR SUPPLIER  | ILITATION, LLC   |                         | STREET ADDRI<br>900 MAGNOLI<br>CAMDEN, AI |   | 1 011             | 21/2013                    |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC  | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION)  | ID<br>PREFII<br>TAG     |   | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) |                   | (X5)<br>COMPLETION<br>DATE |
| F 441                    | Continued From page  |  | F4                      | 41  |   |                   |                            |
|                          | opened ice chest, fille returned it to the bed thermos on the table bedside, came out to cart with the ice ches  | 27 p.m., CNA #10 entered   |                         |   |   |                   |                            |
|                          | gown or gloves, leand placed the overbed to over the bed in from went out to the food of metal cart, removed at the isolation room. To bed with her scrubs to  | n room without donning a ed against the bedrail, able from the side of the bed nt of the resident. The CNA cart, opened the door of the a meal tray, and returned to he CNA leaned against the buching the bedside, and  |                         |   |   |                   |                            |
|                          | overbed table, touche<br>ungloved hand, and I<br>went to the metal foo<br>the cart down the hal<br>Room #5 without was   | e CNA leaned against the ed the plastic glass with the eft the room. CNA #10 then d cart in the hallway, pushed lway to outside Resident shing or sanitizing her hands resident's food tray from   |                         |   |   |                   |                            |
|                          | resident's room and while assisting the re Her uniform touched resident's bed linens. gloves, did not wash and walked down the returned with a straw resident's room, put con the overbed table, the side rails and res then removed her gloroom without washing | a.m., CNA #8 was in the vore gloves but no gown sident with his breakfast. the side rails and the The CNA removed her her hands, left the room, hall to the dining room and The CNA re-entered the on gloves and moved items with her uniform touching ident's bed linens. The CNA res and left the resident's gher hands. The CNA went mand got a pair of socks |                         |   |   |                   |                            |

|                          | OF DEFICIENCIES<br>CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   | 1 ' '               | PLE CONSTRUCTION  G   |           | E SURVEY<br>IPLETED        |
|--------------------------|---|--|---------------------|---|-----------|----------------------------|
|                          |   | 045189   | B. WING             |   | 0.        | C<br>7/27/2015             |
|                          | ROVIDER OR SUPPLIER  S HEALTH AND REHAB   | ILITATION, LLC   |                     | STREET ADDRESS, CITY, STATE, ZIP CODE 900 MAGNOLIA RD CAMDEN, AR 71701                          | · ·       | 12112013                   |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC   | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>.SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF COR<br>(EACH CORRECTIVE ACTION S<br>CROSS-REFERENCED TO THE A<br>DEFICIENCY) | SHOULD BE | (X5)<br>COMPLETION<br>DATE |
| F 441                    | CNA had an incontine plastic bag. The CNA room and without dor the plastic bag in the the linens at the head her uniform, and the touched the control of hands, then left the rohands. The CNA went and touched the reside went down the hall to knocked on the door, handle. The CNA went Nurses Station, touch belt, and placed the gothen went out the bac panel and door and gothen went out the bac panel and door and gothen went out the bac panel and door and gothen went out the bac panel and door and gothen went out the bac panel and door and gothen went out the bac panel and door and gothen went out the bac panel and door and gothen went out the bac panel and door and gothen went out the bac panel and door and gothen went out the bac panel and door and gothen went out the bac panel and door and gothen went out the bac panel and door and gothen went out the bac panel and gothen went out the bac panel and gothen and the Edit the wound." The Edetermined the resident record. The has MRSA, it is protoisolation protocols sh gowning and gloving isolation resident. The k. On 7/27/15 at 5:35 why the resident was stated, "MRSA, past.' staff go in an isolation with the resident, sho | another staff member. The ent brief and placed it in a cre-entered the resident's ining gloves or a gown laid geri-chair. The CNA touched I of the bed, the side rail with bed linens. The CNA in the side rails with her bare boom without washing her it into Resident #2's room dent on the shoulder, then Resident Room #11, and touched the door into down the hall to the sing the door knob, got a gait gait belt around her waist, and touching the control of 2 barrels and returned the ard room. At 8:12 a.m., the wash her hands  p.m., the Director of isked why the resident was DON stated, "He had MRSA DON was asked who ent should be on isolation er was not located in the DON stated, "If someone col." The DON was asked if ould be adhered to, such as before contact with an | F 4                 | 41  |           |                            |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: |   | (X2) MULTIPLE CONSTRUCTION A. BUILDING   |                     |  | (X3) DATE SURVEY<br>COMPLETED |                            |
|--|---|--|---------------------|--|-------------------------------|----------------------------|
|  |   | 045189   | B. WING             |  |                               | C<br><b>07/27/2015</b>     |
|  | ROVIDER OR SUPPLIER  S HEALTH AND REHA  | BILITATION, LLC  |                     | STREET ADDRESS, CITY, STATE, ZIP COD<br>900 MAGNOLIA RD<br>CAMDEN, AR 71701                | •                             | 0172772010                 |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIEN  | STATEMENT OF DEFICIENCIES<br>ICY MUST BE PRECEDED BY FULL<br>R LSC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CO<br>(EACH CORRECTIVE ACTION<br>CROSS-REFERENCED TO THE<br>DEFICIENCY) | I SHOULD BE                   | (X5)<br>COMPLETION<br>DATE |
| F 441  | Continued From pa   | ge 116   | F 44                | 41   |                               |                            |
|  |   | d be handwashing after ent in isolation and stated,  |                     |  |                               |                            |
|  | Chorea, Type 2 Dia<br>Anemia and Anxiety<br>an ARD of 6/12/15<br>scored 0 (0-7 indica   | diagnoses of Huntington's betes Mellitus, Hypertension, v State. The Annual MDS with documented the resident ates severely impaired) on the extensive physical assistance er.  |                     |  |                               |                            |
|  | had just exited an is paper gown, gloves inside the isolation removed a small cleplaced it inside a la housekeeping cart, mask, and gloves, clarge clear plastic boutside of Resident did not wash or san touching the mop to | 2:52 a.m., Housekeeper #1 solation room wearing the solation room wearing the solation room. The Housekeeper ear plastic bag of trash and rege clear plastic bag on the then removed the gown, dropped the items into the ag, and pushed the cart to #6's room. The Housekeeper itize her hands prior to remove it from the cart, then the rent into Resident #6's room. |                     |  |                               |                            |
|  | room of Resident # isolation precaution washing/sanitizing I gloves, the CNA pu the hallway to outsi CNA removed Resi the room, sat the tra   | 2:30 p.m., CNA #11 left the 1, who was on contact s, and without nands or donning a gown or shed a metal food cart down de Resident #6's room. The dent #6's food tray, entered ay down on a table, then went nd washed her hands.   |                     |  |                               |                            |
|  | bedside and remov   | :07 a.m., LPN #4 was at the ed a rolled up brief with feces, ear plastic bag, removed her  |                     |  |                               |                            |

|                          | OF DEFICIENCIES<br>CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   | (X2) MULTI<br>A. BUILDIN | PLE CONSTRUCTION  G   |           | DATE SURVEY<br>COMPLETED   |
|--------------------------|--|--|--------------------------|---|-----------|----------------------------|
|                          |  | 045189   | B. WING _                |   |           | C<br>07/27/2015            |
|                          | ROVIDER OR SUPPLIER  | BILITATION, LLC  |                          | STREET ADDRESS, CITY, STATE, ZIP CODE 900 MAGNOLIA RD CAMDEN, AR 71701                          |           | 0112112013                 |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIEN   | STATEMENT OF DEFICIENCIES<br>ICY MUST BE PRECEDED BY FULL<br>R LSC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG      | PROVIDER'S PLAN OF COR<br>(EACH CORRECTIVE ACTION :<br>CROSS-REFERENCED TO THE A<br>DEFICIENCY) | SHOULD BE | (X5)<br>COMPLETION<br>DATE |
| F 441                    | Continued From pa  | ge 117   | F 4                      | 41  |           |                            |
|                          | the resident's pants<br>sanitizing her hands<br>resident to assist th<br>before the LPN was  | gloves into the bag then pulled up without washing or s. The LPN then touched the e resident in transferring shed her hands.  diagnoses of Type 2 Diabetes   |                          |   |           |                            |
|                          | Cerebrovascular Ac<br>Dementia. The Qua<br>7/21/15 documente   | d, Alzheimer's Disease, scident (CVA), and Vascular arterly MDS with an ARD of d the resident scored 4 (0-7 mpaired) on the BIMS and had   |                          |   |           |                            |
|                          | glucose monitor tes<br>the resident. After the<br>finished, the LPN by<br>resident's room and<br>notebook on top of                      | p.m., LPN #3 performed a t for the blood sugar level for the glucose check was rought the monitor out of the placed it on top of a small the medication cart without nitor with any type of sanitizer. |                          |   |           |                            |
|                          | Progressive Muscul<br>Diabetes Mellitus, E<br>Frontal Sinusitis, ar<br>Quarterly MDS with<br>documented the res<br>indicates cognitively | sident scored 15 (13-15<br>intact) on the BIMS and<br>to total dependence on staff   |                          |   |           |                            |
|                          | medication cart to o<br>without washing or<br>exiting an isolation<br>resident's room the<br>cart. At the cart the                       | p.m., LPN #4 pushed the outside the resident's room sanitizing her hands after room. The LPN went into the noreturned to the medication LPN opened a drawer, pulled at of the drawer, then began       |                          |   |           |                            |

|                          | OF DEFICIENCIES<br>CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   | (X2) MUL<br>A. BUILD |     | CONSTRUCTION  | (X3) DATE<br>COMP | SURVEY<br>LETED            |
|--------------------------|--|---|----------------------|-----|---|-------------------|----------------------------|
|                          |  | 045189  | B. WING              |     |   |                   | 07/0045                    |
| NAME OF P                | ROVIDER OR SUPPLIER  | 045105  | B. WING              | 9   | TREET ADDRESS, CITY, STATE, ZIP CODE  | 07/               | 27/2015                    |
|                          | S HEALTH AND REHAB   | ILITATION, LLC  |                      | 9   | 00 MAGNOLIA RD<br>CAMDEN, AR 71701  |                   |                            |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC  | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>.SC IDENTIFYING INFORMATION)   | ID<br>PREF<br>TAG    |     | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B) CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) |                   | (X5)<br>COMPLETION<br>DATE |
| F 441                    | pharmacy delivery per gave the LPN a large pharmacy logo. The removed the medicat signed an invoice, representation cards back medication cards back medication cards into to the delivery person her to sign for those." delivery person the sawent down the hall to then finished dispensive resident into a plastic how many medication stated, "6 in cup, 7 to LPN #4 picked up the poured a cup of water esident's room and hof water and the cup washing or sanitizing the LPN returned to the without washing or satte glucose meter to cart.  9. On 7/22/15 at 5:15 the glucometer should after each resident us Usually we have sani asked if she had sani LPN stated, "No." The hands should be was each resident's care at The LPN was asked if the medication in the left of t | ars into a plastic cup. A strson arrived at the cart and white paper sack with the LPN opened the sack, ion cards from the sack, placed some of the k into the sack, placed the cart drawer, then stated a, "You'll go to her side. Get LPN #4 then handed the ack and the delivery person the secured unit. The LPN ing medications for the cup. The LPN was asked as the resident got and tal, 2 same." At 5:15 p.m., a large water pitcher and r, then went into the manded the resident the cup of medications without her hands. At 5:17 p.m., the medication cart, and anitizing her hands moved the side of the medication  5 p.m., LPN #3 was asked if d be cleaned and sanitized se and the LPN stated, "Yes. tizer wipes." The LPN was tized the glucometer and the le LPN was asked if her hed or sanitized between and the LPN stated "Yes." if she should wash her in isolation resident's bedside | F                    | 441 |   |                   |                            |

|                          | OF DEFICIENCIES<br>F CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  | ' '                 | IPLE CONSTRUCTION IG  |                              | TE SURVEY<br>MPLETED       |
|--------------------------|---|---|---------------------|---|------------------------------|----------------------------|
|                          |   | 045189  | B. WING _           |   |                              | C<br><b>7/27/2015</b>      |
|                          | ROVIDER OR SUPPLIER   |   |                     | STREET ADDRESS, CITY, STATE, ZIP COL<br>900 MAGNOLIA RD<br>CAMDEN, AR 71701                 |                              | 7/21/2015                  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC   | TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CO<br>( (EACH CORRECTIVE ACTIO<br>CROSS-REFERENCED TO THE<br>DEFICIENCY) | N SHOULD BE<br>E APPROPRIATE | (X5)<br>COMPLETION<br>DATE |
| F 441                    | Dementia and Convulvith an ARD date of resident scored 6 (0-impaired) on the BIM assistance of 1 persoduressing and personassistance of 2 persodures incontinent of bladder a. On 7/22/15 at 9:12 resident's bathroomy been incontinent. The facing the commodesthere was as white to soiled incontinent brief in plocompleted the resident without washing her door knob to the biothall touching a resident pushed the resident soiled towel and soiled 11. Resident #2 had Dementia and Convul Minimum Data Set (Neference Date (ARI the resident scored 5 impaired) on the Brief resident required extiperson for personal fincontinent of bowel | diagnosis of Vascular ulsions. The Annual MDS 5/4/15 documented the 7 indicates severely S, required extensive on for bed mobility, transfers, all hygiene, extensive on for toilet use, and was r and bowel.  2 a.m., CNA #3 was in the with the resident, who had a resident was standing, On the right side of the sink, owel with a yellow tint and a ref laying on the sink. The red towel and the soiled astic bags. The CNA had inent care, then left the room thands. The CNA touched the reazard room, went down the rent in a merry walker, and down the hall before washing did not clean the sink in the was contaminated with the red incontinent brief.  diagnoses of Presenile relations. The Quarterly MDS) with Assessment D) of 7/14/15 documented in (0-7 indicates severely of Interview for Mental Status, rensive assistance of 1 | F4                  | 41  |                              |                            |

| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION |  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   | ` ′                | FIPLE CONSTRUCTION<br>NG  |                                    | (X3) DATE SURVEY<br>COMPLETED |  |
|---|--|--|--------------------|---|------------------------------------|-------------------------------|--|
|   |  | 045189   | B. WING            |   |                                    | C<br>07/27/2015               |  |
|   | ROVIDER OR SUPPLIER  | HABILITATION, LLC  |                    | STREET ADDRESS, CITY, STATE, ZIP<br>900 MAGNOLIA RD<br>CAMDEN, AR 71701 | •                                  |                               |  |
| (X4) ID<br>PREFIX<br>TAG                            | (EACH DEFICI   | Y STATEMENT OF DEFICIENCIES<br>ENCY MUST BE PRECEDED BY FULL<br>OR LSC IDENTIFYING INFORMATION)  | ID<br>PREFI<br>TAG |   | CTION SHOULD BE<br>THE APPROPRIATE | (X5)<br>COMPLETION<br>DATE    |  |
| F 441   | provided incontine were pulled down wet with urine. The saturated with urine incontinent care. I perineal area with with the same sur labia area and growers area and growers area and growers area and growers area and growers. We are the cloth had a dawaring the same the rectal area and cloth. The resident before the cloth resame soiled glovers are soile | page 120 38 p.m., CNA #8 and #3 ent care. The resident's pants and the crotch of the pants was e incontinent brief was ne. CNA #3 performed The CNA cleansed the front water only. The CNA wiped face of the cloth across the oin area. The CNAs turned the ght side and CNA #3 continued ontinent care. The CNA wiped face of the cloth across the //hen CNA #3 wiped the rectum, inkish substance on the cloth. e soiled gloves, CNA #3 wiped d a darkish substance soiled the it was wiped 3 more times eturned free of feces. With the est the CNA touched the incontinent brief and the ants, and placed the lift pad t before changing gloves.  ad diagnoses of Schizophrenia The Quarterly MDS with an ARD ented the resident scored 0 (0-7 or impaired) on the BIMS, esistance of one person for bed fers, extensive assistance of 1 al hygiene, was incontinent of el and at risk for developing  2 p.m., the resident was sitting in the hallway and CNA #8 ent down the hall to his room. At ident was taken to the resident's esident was able to stand with the CNA stated the bathroom | F                  | 441   |                                    |                               |  |

| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION |   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  | (X2) MULTIPLE CONSTRUCTION  A. BUILDING |     | (X3) DATE SURVEY<br>COMPLETED   |  |                            |
|---|---|--|---|-----|---|--|----------------------------|
|   |   | 045189   | B. WING                                 |     |   |  | 27/ <b>2015</b>            |
|   | ROVIDER OR SUPPLIER  S HEALTH AND REHAB   | ILITATION, LLC   |   | ,   | STREET ADDRESS, CITY, STATE, ZIP CODE<br>200 Magnolia RD<br>Camden, ar 71701                                  |  | 2772010                    |
| (X4) ID<br>PREFIX<br>TAG                            | (EACH DEFICIENC   | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>.SC IDENTIFYING INFORMATION)  | ID<br>PREFI<br>TAG                      |     | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) |  | (X5)<br>COMPLETION<br>DATE |
| F 441<br>F 498<br>SS=F                              | gone to the bathroom. The Resident was in placed a towel under incontinent brief was urine. CNA #8 provide peri-wash. The CNA penis 2 times with the in a back and forth mworn for incontinent obrief on the resident,  | e the resident next door had and urinated in the floor. sock feet, and the CNA his feet. The resident's removed and saturated with ed the incontinent care with wiped across the top of the e same surface of the cloth otion. With the same gloves are, the CNA placed a clean pulled up his pants, and did ent's socks that had came ne.             |   | 441 |   |  |                            |
|   | to demonstrate comp<br>techniques necessary<br>needs, as identified the<br>assessments, and dead<br>This REQUIREMENT<br>by:<br>Complaint #20354 (A<br>(all or in part) in these<br>Based on observation<br>interview, the facility of<br>Nursing Assistants (Conecessary skills and of<br>incontinent care to pro-<br>hygiene and preventor<br>repositioning procedured | to care for residents' nrough resident scribed in the plan of care.  It is not met as evidenced a R00018459) substantiated e findings:  In, record review and failed to ensure Certified and experiments for providing pomote good personal podors and turning and the sure to prevent the potential essure ulcers for 2 of 6 (Resident #1, 2, #3, #4, |   |     |   |  |                            |

| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION |  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  | 1 ' '             | (X2) MULTIPLE CONSTRUCTION A. BUILDING |   |     | (X3) DATE SURVEY<br>COMPLETED |  |
|---|--|---|-------------------|--|---|-----|-------------------------------|--|
|   |  |   | 71. 55125         | _                                      |   | (   | 0                             |  |
|   |  | 045189  | B. WING           |  |   | 07/ | 27/2015                       |  |
|   | ROVIDER OR SUPPLIER  S HEALTH AND REHAE  | BILITATION, LLC   | 1                 | 90                                     | TREET ADDRESS, CITY, STATE, ZIP CODE<br>00 MAGNOLIA RD<br>AMDEN, AR 71701   | •   |                               |  |
| (X4) ID<br>PREFIX<br>TAG                            | (EACH DEFICIENC  | TATEMENT OF DEFICIENCIES<br>CY MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION)   | ID<br>PREF<br>TAG |  | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD B<br>CROSS-REFERENCED TO THE APPROPRIA<br>DEFICIENCY) |     | (X5)<br>COMPLETION<br>DATE    |  |
| F 498   | (Resident #1 and 9) developing pressure East Hall; isolation protential for spread (Resident #1) case in contact isolation and (Resident #1 and #6 and #6 thru #13) casice water from therm water pitcher; condubelt to prevent the processe mix residents wand required assistated utilized proper hands protocols between diprevent the spread of #1, #2, #4, and #6) cand #6 thru #13) cas assistance with active These failed practice 19 residents who residents who were incontinent by Licensed Practice 7/24/15.  9 residents who residents of Nursing (1 and 1 an | who were at risk for ulcers, and resided on the rotocols to prevent the of infections for 1 of 1 mix resident who was in 1 universal precautions for 2 of 12 (Residents #1 thru #4 is e mix residents who received it is and the medication cart cting transfers using a gait otential for injuries for 1 is residents #3, #4, and #6) who required gait belt transfer nace of 2 staff persons; and washing / glove changing irty and clean tasks to of infection for 6 (Residents if 12 (Residents #1 thru #4 is e mix residents who required rities of daily living.  The shad the potential to affect:  Sided on the East Wings and it according to a list provided at Nurse (LPN) #10 on  ded on the East wing and loping pressure ulcers, ovided by the Assistant ADON) on 8/10/15;  isolation, according to | F                 | 498                                    |   |     |                               |  |

|                          |  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   | (X2) MULT<br>A. BUILDII | TIPLE CONSTRUCTION  NG  | (X3) DATE SURVEY COMPLETED |                            |
|--------------------------|--|--|-------------------------|---|----------------------------|----------------------------|
|                          |  | 045189   | B. WING _               |   |                            | C<br>07/27/2015            |
|                          | ROVIDER OR SUPPLIER  S HEALTH AND REHAE  | BILITATION, LLC  |                         | STREET ADDRESS, CITY, STATE, ZIP COD<br>900 MAGNOLIA RD<br>CAMDEN, AR 71701       | •                          | 0172172010                 |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC  | TATEMENT OF DEFICIENCIES<br>CY MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG     | PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY) | I SHOULD BE                | (X5)<br>COMPLETION<br>DATE |
| F 498                    | medication cart and according to a list pro 8/10/15;  7 residents on the Eassistance of 2 person for transfers, as door 7/24/15 by the Direct The findings are:  1. The job description Assistant received at the Business Office In "Provide quality nursimplement specific pureport pertinent infi supervisor Essenti  | resided on the East Wing, by ided by the ADON on ast Wing who required the cons and the use of a gait belt umented on a list provided on tor of Nursing (DON).  In titled Certified Nursing t 9:00 a.m. on 7/27/15 from Manager documented, ing care to residents; rocedures and programs; ormation to the immediate al Job Duties and | F                       | 198   |                            |                            |
|                          | needs of residents we withincontinent caor other needs in k care requirements, a Provide care that maintegrity to prevent p damage by changing turning, repositioning applying moisturizers. Lift, move, and transbody mechanics or liprevention18. Per in accordance with profection control prochand washing, use of the control prochand washing, use of the care requirements. | edures including thorough f disposable gloves where r disposal of soiled materials.  |                         |   |                            |                            |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION |  | I DENTIFICATION NUMBER:  |                     | MULTIPLE CONSTRUCTION JILDING  |                               | (X3) DATE SURVEY<br>COMPLETED |  |
|--|--|--|---------------------|--|-------------------------------|-------------------------------|--|
|  |  | 045189   | B. WING             |  | ,                             | C<br><b>7/27/2015</b>         |  |
|  | ROVIDER OR SUPPLIER  |  |                     | STREET ADDRESS, CITY, STATE, ZIP CO 900 MAGNOLIA RD CAMDEN, AR 71701                   |                               | 7/27/2015                     |  |
| (X4) ID<br>PREFIX<br>TAG                         | (EACH DEFICIENC  | TATEMENT OF DEFICIENCIES<br>CY MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF C<br>(EACH CORRECTIVE ACTIO<br>CROSS-REFERENCED TO TH<br>DEFICIENCY | ON SHOULD BE<br>E APPROPRIATE | (X5)<br>COMPLETION<br>DATE    |  |
| F 498  | (MRSA), Peripheral Pressure Ulcer, Gan Knee, and Amputation Admission Minimum Assessment Referer documented the resignation of the indicates moderately. Interview for Mental extensive to total assoft daily living, and has a The Care Plan darequire isolation due the isolation requirer.  b. On 7/22/15 at 8:10 Assistant (CNA) #7 without donning a gomeal tray out of the interaction to the metal opening the door with her hands. At 8:19 isolation room without went to the bedside thermos, and went to the hallway. The CN opened ice chest, fill returned it to the bedside, came out to cart with the ice chest.  c. On 7/22/15 at 12: the resident's isolation gown or gloves, lear placed the overbed to over the bed in from the control of the cont | Staphylococcus Aureus Vascular Disease, Stage 4 grene, Amputation Below on Above Knee. The Data Set (MDS) with an nce Date of 7/16/15 Ident scored 11 (8-12 Impaired) on the Brief Status (BIMS), required sistance of staff for activities ad MRSA infection.  Ated 7/21/15 documented, "I to MRSAEducateabout ments"  D a.m., Certified Nursing entered the isolation room own or gloves, removed the solation room, and returned food cart in the hallway, hout washing or sanitizing a.m., CNA #7 entered the ut donning a gown or gloves, table, picked up the water of the ice chest on a cart in NA held the thermos over the led the thermos with ice, and diside to place the water e. The CNA then left the of the hallway, and pushed the | F 4                 | 98   |                               |                               |  |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   |  | (X2) MULT<br>A. BUILDIN | IPLE CONSTRUCTION  NG   |           | (X3) DATE SURVEY<br>COMPLETED |  |
|--|--|-------------------------|---|-----------|-------------------------------|--|
|  | 045189   | B. WING _               |   |           | C<br><b>07/27/2015</b>        |  |
| NAME OF PROVIDER OR SUPPLIER PINE HILLS HEALTH AND REF   |  |                         | STREET ADDRESS, CITY, STATE, ZIP CODE<br>900 MAGNOLIA RD<br>CAMDEN, AR 71701                  |           | 07/27/2013                    |  |
| PREFIX (EACH DEFICI  | Y STATEMENT OF DEFICIENCIES<br>IENCY MUST BE PRECEDED BY FULL<br>OR LSC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG     | PROVIDER'S PLAN OF COF<br>(EACH CORRECTIVE ACTION<br>CROSS-REFERENCED TO THE /<br>DEFICIENCY) | SHOULD BE | (X5)<br>COMPLETION<br>DATE    |  |
| the isolation room bed with her scrul moved the table. overbed table, too ungloved hand, a went to the metal the cart down the Room #5 without and removed ano the cart at 12:30 g.  2. Resident #6 has Chorea, Type 2 Dhamia, and Anxi with an ARD of 6/scored 0 (0-7 indi BIMS and require from staff for transform staff for transform staff for transform the hall room without having hands. The CNA tray, entered the resident in the edge of the wistopped the whee #7 was on the right CNA #8 joined he underneath the resident's pansion. | ed a meal tray, and returned to in. The CNA leaned against the bis touching the bedside, and The CNA leaned against the ciched the plastic glass with the ind left the room. CNA #10 then food cart in the hallway, pushed hallway to outside Resident washing or sanitizing her hands ther resident's food tray from o.m.  and diagnoses of Huntington's plabetes Mellitus, Hypertension, ety State. The Annual MDS 12/15 documented the resident cates severely impaired) on the diextensive physical assistance | F 4                     |   |           |                               |  |

| 1 ,                      |   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  | IDENTIFICATION NUMBER: |              | MULTIPLE CONSTRUCTION  JILDING  |              |                            |
|--------------------------|---|---|------------------------|--------------|---|--------------|----------------------------|
|                          |   | 045189  | B. WING                |              |   |              | C<br>(27/2045              |
|                          | ROVIDER OR SUPPLIER S HEALTH AND REHAB  |   |                        | STREET ADDRE |   | <u>  077</u> | 27/2015                    |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC   | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG    | (EA          | PROVIDER'S PLAN OF CORRECTION<br>ACH CORRECTIVE ACTION SHOULD E<br>SS-REFERENCED TO THE APPROPRI<br>DEFICIENCY) | 3E           | (X5)<br>COMPLETION<br>DATE |
| F 498                    | and lifted upwards to wheelchair to repositi  | pull the resident up in the on the resident upright in the pushed the wheelchair into t 11:18 a.m.  | F4                     | 98           |   |              |                            |
|                          | Dementia and Convu<br>Minimum Data Set (M<br>Reference Date (ARI<br>the resident scored 5<br>impaired) on the Brier<br>resident required exter<br>person for personal hincontinent of bowel a | Isions. The Quarterly IDS) with Assessment D) of 7/14/15 documented (0-7 indicates severely f Interview for Mental Status, ensive assistance of 1   |                        |              |   |              |                            |
|                          | 10/13/14 documented extensive assistance dressing, toileting, pelocomotion. Goal I will cares met by staff on incont. [incontinent] of please give me incontinent and or pull up please       | ve Care Plan dated for d, "Problem/Need, I require with bed mobility, transfers, irsonal hygiene, bathing, and ll continue to have all my going. Approaches, If I am if B&B [bowel and bladder] t. care and if I wear a brief change Please turn and y] 2 hours and PRN [as |                        |              |   |              |                            |
|                          | [related to] impaired r<br>B&B. Goal I will not e<br>conditions r/t incontin<br>me Q 2 H [hours] and  | of for altered skin integrity r/t<br>mobility and incontinent of<br>xperience any skin<br>ence. Approaches Toilet<br>I PRN, with peri-care and<br>tion after each toileting and   |                        |              |   |              |                            |
|                          | b. The Braden Risk A  | ssessment Report dated  |                        |              |   |              |                            |

| AND DIAN OF CORRECTION IDENTIFICATION NUMBER: |  | ` ′  | LE CONSTRUCTION     | (X3) DATE SURVEY<br>COMPLETED  |                 |  |
|---|--|--|---------------------|--|-----------------|--|
|   |  | 045189   | B. WING             |  | C<br>07/27/2015 |  |
|   | ROVIDER OR SUPPLIER  | BILITATION, LLC  |                     | STREET ADDRESS, CITY, STATE, ZIP CODE 900 MAGNOLIA RD CAMDEN, AR 71701                     | ,               |  |
| (X4) ID<br>PREFIX<br>TAG                      | (EACH DEFICIEN   | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP | O BE COMPLETION |  |
| F 498   | indicated a Risk Lev c. On 7/22/15 at 8:19 sitting up in the whee d. On 7/22/15 at 8:2 the resident was sitti room. The resident v line of sight. e. On 7/22/15 at 9:3 Assistant (CNA) #8 of The CNA washed th changed her shirt. T check the resident for f. On 7/22/15 at 9:3 her self down the har room area for activiti g. On 7/22/15 from this Surveyor observ room playing bingo. h. On 7/22/15 at 11: wheeled her self dow around and went back i. On 7/22/15 from 1 p.m., the resident re the dining room, in of Surveyor. j. On 7/22/15 at 12:2 propelling self in the CNA #8 was asked to be checked for incore | I a Risk Score of 15, which el of Mild.  5 a.m., the resident was elchair in her room.  10 a.m., 8:30 a.m., and 9:15 ing up in the wheelchair in her was kept in this Surveyor's  10 a.m., Certified Nursing entered the resident's room. The resident's face and the CNA did not reposition or or incontinence.  15 a.m. the resident wheeled is and entered the dining | F 49                |  |                 |  |

|                          |  | IDENTIFICATION NUMBER:   |                     | TIPLE CONSTRUCTION   |                              | (X3) DATE SURVEY<br>COMPLETED |  |
|--------------------------|--|--|---------------------|--|------------------------------|-------------------------------|--|
|                          |  | 045189   | B. WING             |  |                              | C<br><b>07/27/2015</b>        |  |
|                          | ROVIDER OR SUPPLIER S HEALTH AND REHAB   |  |                     | STREET ADDRESS, CITY, STATE, ZIP COD<br>900 MAGNOLIA RD<br>CAMDEN, AR 71701                | •                            | 1112112015                    |  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC  | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CO<br>(EACH CORRECTIVE ACTION<br>CROSS-REFERENCED TO THE<br>DEFICIENCY) | N SHOULD BE<br>E APPROPRIATE | (X5)<br>COMPLETION<br>DATE    |  |
| F 498                    | resident. The CNA st resident before she wasked, "What time did stated, 10:30 a.m. The the resident's room a her face and changed her [for incontinence] stated, "I didn't check sitting in the wheelch approximately 4 hour not checked for incontinence of the stand lift and then lef with the Marisa Mechanical lift. The Costand lift and then lef with the Marisa Mechanical lift. The Costand lift and then lef with the Marisa Mechanical lift. The Costand lift and then lef with the Marisa Mechanical lift. The Costand lift and then lef with the same for transferred to the bed provided the incontinents were wet with the was saturated with unincontinent care. The perineal area with was with the same surfact labia area and groin a resident on her right to perform the incontinent the same surfact rectum 2 times. When the cloth had a darkis Wearing the same so applied the clean income were asked if they we incontinent care and CNA's were asked if area again. CNA #3 were again. CNA #3 were again. | last time you checked this ated she had checked the vent to lunch. The CNA was d you go to lunch?" The CNA are CNA asked, "You were in the 9:30 a.m. and you washed dher shirt. Did you check at that time?" The CNA are that time?" The conduction and the sair from 8:15 until 12:25 p.m. are sair from 8:15 until 12:25 p.m | F 4                 | 98   |                              |                               |  |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |  | (X2) MULT<br>A. BUILDIN  | IPLE CONSTRUCTION  NG |   | (X3) DATE SURVEY<br>COMPLETED |                            |
|---|--|--|-----------------------|---|-------------------------------|----------------------------|
|   |  | 045189   | B. WING _             |   |                               | C<br>07/27/2015            |
|   | ROVIDER OR SUPPLIER  S HEALTH AND REHA   | BILITATION, LLC  |                       | STREET ADDRESS, CITY, STATE, ZIP COD<br>900 MAGNOLIA RD<br>CAMDEN, AR 71701       | E                             | 0112112013                 |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIEN   | STATEMENT OF DEFICIENCIES<br>ICY MUST BE PRECEDED BY FULL<br>R LSC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG   | PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY) | I SHOULD BE                   | (X5)<br>COMPLETION<br>DATE |
| F 498   | Continued From page  | ge 129   | F 4                   | .98   |                               |                            |
|   | skin was cleansed of gloves the CNA tour incontinent brief, the placed the lift pad unchanging gloves.  4. Resident #4 had and Depression. The of 4/29/15 document indicates severely in required limited ass  | imes before the resident's of feces. With the same soiled ched the resident's clean e resident's clean pants, and nder the resident before  diagnoses of Schizophrenia le Quarterly MDS with an ARD sted the resident scored 0 (0-7 mpaired) on the BIMS, istance of one person for bed  |                       |   |                               |                            |
|   | person for personal  | rs, extensive assistance of 1 hygiene, was incontinent of and at risk for developing   |                       |   |                               |                            |
|   | dated 6/5/15 docum<br>require limited assist<br>transfers, locomotion<br>hygiene and bathing<br>decline with my ADI<br>function. Approache<br>please give me income<br>and or pull up please<br>turning and reposition<br>assist q 2 hours and<br>at risk for pressure<br>impaired mobility. G | Comprehensive Care Plan nented, "Problem need, I stance with bed mobility, an, dressing, toileting, personal g. Goal, I will not have further [Activity Daily Living] es, If I am incont. of B&B ont. care and if I wear a brief se change. Please assist with oning and encourage me to d PRN." Problem Need, I am ulcers r/t incontinent of B&B soal, I will not have any skin ches, Reposition me Q 2 H.  2 H and PRN." |                       |   |                               |                            |
|   | propelling the whee<br>8:20 a.m., CNA #8 and washed the res<br>resident's hair. The  | 18 a.m., the resident was self Ichair down the East hall. At entered the resident's room ident's face and brushed the resident was not repositioned he resident wheeled himself  |                       |   |                               |                            |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |   | (X2) MULTI<br>A. BUILDIN   | PLE CONSTRUCTION  G |  | (X3) DATE SURVEY<br>COMPLETED |                            |
|---|---|--|---------------------|--|-------------------------------|----------------------------|
|   |   | 045189   | B. WING             |  | 0.                            | C<br>7/ <b>27/2015</b>     |
|   | ROVIDER OR SUPPLIER S HEALTH AND REHA   | BILITATION, LLC  |                     | STREET ADDRESS, CITY, STATE, ZIP CODE 900 MAGNOLIA RD CAMDEN, AR 71701                             |                               | 112112013                  |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIEN  | STATEMENT OF DEFICIENCIES<br>CY MUST BE PRECEDED BY FULL<br>R LSC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORR<br>(EACH CORRECTIVE ACTION SI<br>CROSS-REFERENCED TO THE AF<br>DEFICIENCY) | HOULD BE                      | (X5)<br>COMPLETION<br>DATE |
| F 498   | Continued From pagout of the room.  | ge 130   | F 4                 | 98   |                               |                            |
|   | the wheelchair prop   | 38 a.m., the resident was in elling himself down the ent was observed by this s.   |                     |  |                               |                            |
|   | the resident was sitt   | 40 a.m., 9:30 a.m., 9:33 a.m., ing in the wheelchair without or checked for incontinence.  |                     |  |                               |                            |
|   | e. On 7/22/15 at 9:3 himself to the dining  | 33 a.m., the resident wheeled room for activities.   |                     |  |                               |                            |
|   |   | 9:33 a.m. through 11:00 a.m., the dining room at an activity   |                     |  |                               |                            |
|   | a.m., the resident w  | 11:00 a.m. through 12:15 as in the wheelchair in the being repositioned and lence.   |                     |  |                               |                            |
|   |   | :45 p.m., the resident was elf in a wheelchair down the  |                     |  |                               |                            |
|   | in the wheelchair in pushed the resident The CNA stated that to get clean linen to p.m., the resident w bathroom. The resident w bathroom. The resident w size and 25 minutes. The with limited assistant | 2 p.m., the resident was sitting the hallway and CNA #8 down the hall to his room. It she was waiting for the key change the resident. At 1:45 as taken to the resident's lent was in the wheelchair 1:45 p.m. without being oned, approximately 5 hours e resident was able to stand ice. The CNA stated the wet the resident next door |                     |  |                               |                            |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |  | (X2) MULT<br>A. BUILDIN   | PLE CONSTRUCTION  IG |  | (X3) DATE SURVEY<br>COMPLETED |                            |
|---|--|---|----------------------|--|-------------------------------|----------------------------|
|   |  | 045189  | B. WING _            |  |                               | C<br>07/27/2015            |
|   | ROVIDER OR SUPPLIER  S HEALTH AND REHA   | BILITATION, LLC   |                      | STREET ADDRESS, CITY, STATE, ZIP CODE<br>900 MAGNOLIA RD<br>CAMDEN, AR 71701                     |                               | 0112112013                 |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIEN   | STATEMENT OF DEFICIENCIES<br>ICY MUST BE PRECEDED BY FULL<br>R LSC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG  | PROVIDER'S PLAN OF CORI<br>(EACH CORRECTIVE ACTION S<br>CROSS-REFERENCED TO THE A<br>DEFICIENCY) | SHOULD BE                     | (X5)<br>COMPLETION<br>DATE |
| F 498   | floor. The Resident placed a towel unde incontinent brief wa urine. CNA #8 proviperi-wash. The CNA penis 2 times with the in a back and forth cleanse the resident With the same glow the CNA placed a copulled up his pants, resident's socks that urine.  5. On 7/23/15 at 2: Residents #2 and # incontinence and win the wheelchair the CNA stated, "No." often should the resincontinence and the up in the wheelchair hours." The CNA vensuring that the reincontinence and be stated, "Skin breaked, "The CNA stated, "Skin breaked, "Skin breaked, "Skin breaked, "Skin breaked, "What is the CNA stated, "What is the stated | hroom and urinated in the was in sock feet, the CNA or his feet. The resident's is removed and saturated with ded the incontinent care with a wiped across the top of the ne same surface of the cloth motion. The CNA did not t's buttocks or inner thighs. The ses worn for incontinent care, lean brief on the resident and and did not change the thad came in-contact with the | F4                   | 98   |                               |                            |
|   | who does the training  | :05 p.m., the DON was asked ng for the CNAs regarding le DON stated, "The DEQ   |                      |  |                               |                            |

| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                     |   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   | (X2) MULTIPLE CONSTRUCTION A. BUILDING |   | (X3  | (X3) DATE SURVEY<br>COMPLETED |  |
|---|---|--|--|---|--|-------------------------------|--|
|   |   | 045189   | B. WING                                |   |  | C<br>07/27/2015               |  |
| NAME OF PROVIDER OR SUPPLIER  PINE HILLS HEALTH AND REHABILITATION, LLC |   |  |  | 900 MAGNOLIA RD CAMDEN, AR 71701            |  |                               |  |
| (X4) ID<br>PREFIX<br>TAG  | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  |  | ID<br>PREFIX<br>TAG                    | X (EACH CORRECTIVE A<br>CROSS-REFERENCED TO | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  (X5)  COMPLETION DATE |                               |  |
| F 498   | [Director of Educatio [LPN #10]."  7. On 7/27/15 at 5:1 her job duties. The L of Education and Qu who does the training LPN stated, "The tra [Arkansas Initiative FLPN was asked how checked off on incon "Every 3 months." The CNAs are hired, who stated, "The compant 3-day program, that As of now, they shad the CNA off on incontrainer CNAs - there [#9] - the trainers are was asked if, during of the skin should be | e 132 n and Quality], that would be  0 p.m., LPN #10 was asked PN stated, "I'm the Director ality." The LPN was asked g for incontinent care and the ining is done by AIPP Performance Program]." The often the CNAs were tinent care. The LPN stated, he LPN was asked, when he does the training? The LPN by has a new program, a his going to be implemented. How a CNA and they check tinent care and 1 of the hare 2 trainer [CNA's #8] and he trained by AIPP." The LPN incontinent care, all surfaces he cleansed of urine and why. he, to prevent skin breakdown." | F                                      | 498   | NCT)   |                               |  |
|   | 8. On 7/27/15 at 6:55 how often CNAs wer skills such as transfe handwashing. The LThe LPN was asked   | skills and stated, "I'm not  |  |   |  |                               |  |