STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045357	A. BUILDING _____ B. WING _____	09/17/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER HEALTH AND REHABILITATION, LLC	3600 RICHARDS ROAD NORTH LITTLE ROCK, AR 72117

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS Note: The CMS-2567 (Statement of Deficiencies) is an official, legal document. All information must remain unchanged except for entering the plan of correction, correction dates, and the signature space. Any discrepancy in the original deficiency citation(s) will be reported to the Dallas Regional Office (RO) for referral to the Office of the Inspector General (OIG) for possible fraud. If information is inadvertently changed by the provider/supplier, the State Survey Agency (SA) should be notified immediately.	F 000		
F 248 SS=E	483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure activities were planned and implemented to meet a resident's individual interests in order to promote well-being and improve quality of life for 1 (Resident #5) of 1 case mix residents who preferred to stay in his room instead of participating in group activities. This failed practice had the potential to affect 41 residents who either required 1 on 1 activities or preferred self- directed in room activities, according to a list provided by the Director of Nursing on 9/17/15. (total census: 116) The findings are:	F 248		

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

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Resident #5 had diagnoses of Hypertension, Congestive Heart Failure, Diabetes Mellitus, Acute/Chronic Respiratory Failure and Cognitive Communication Deficit. The Admission Minimum Data Set (MDS) with an assessment reference date (ARD) of 4/16/15 documented the resident's preferences for customary routine and activities, which were all coded as very important to the resident, were listening to music, being around animals/pets, keeping up with news, doing favorite activities and going outside when weather good

a. A Lifestyle Activities Preferences Assessment form dated 4/16/15 documented "...Current Recreational Interests (Select all that apply) ... Cooking/Baking ... Exercising ... Indoor/Outdoor Gardening ... Music Listening ... Pet visits ... Radio Listening ... Spiritual Activities ... Sports ... Table Games/Cards ... Travels ... TV Viewing..."

b. The Quarterly MDS with an ARD of 7/8/15 documented the resident scored 14 (13-15 indicates cognitively intact) on a Brief Interview for Mental Status, required extensive assistance of 2 persons for bed mobility and transfers and required extensive assistance of 1 person for locomotion on and off unit.

c. An Activities Departmental Note dated 7/13/15 at 9:46 a.m. documented "...he [resident] continues to enjoy football, basketball, dominoes and bingo ...Resident is often seen this quarter in room or on phone when asked to be assistanced [sic] to activities resident declines. Resident requires assistance to and from activities ..."

d. On 9/14/15 at 1:08 p.m., the resident was in his room, sitting in his wheelchair eating lunch.

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There were no visible board games, reading materials, radio or compact disc player in his room.

e. On 9/14/15 at 4:56 p.m., resident was in his wheelchair at the entrance of his room. The resident was sleeping. There were no visible board games, reading materials, radio or compact disc player in his room.

f. On 9/15/15 at 10:50 a.m., the resident was up in his wheelchair in the hallway next to his room. There were no visible board games, reading materials, radio or compact disc player in his room.

g. On 9/15/15 at 12:05 p.m., the resident was in his room, up in his wheelchair watching television.

h. On 9/16/15 at 8:30 a.m., the resident was lying in bed asleep. There were no visible board games, reading materials, radio or compact disc player in his room.

i. On 9/16/15 at 11:00 a.m., the resident was asked what activities he enjoyed doing. He stated he did not care much about reading and did not read very much, but did watch TV. When asked about listening to music, the resident stated, "I do love some music; I love blue grass music. I do not have any music to listen to in my room and don't really like to go to them big groups [group activities]."

j. On 9/16/15 at 11:02 a.m., the Activity Director was asked, what activities were provided for Resident #5. She stated she did 'socialization' with the resident, that the resident was self-directed and that he refused to attend group

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F 248	Continued From page 3 activities. The Activities Director was asked to look at the resident's preferences for activities, including newspapers, magazines and music. She stated, "I see what you mean; I could take newspapers and music to the resident's room."	F 248		
F 282 SS=E	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure compression stockings were applied according to the physician's plan of care, to improve circulation and prevent potential complications for 1 (Resident #5) of 1 case mix residents who had physician orders for compression stockings. This failed practice had the potential to affect 7 residents who had physician orders for compression stockings per a list provided by the Director of Nursing (DON) on 9/17/15 at 8:45 a.m. The findings are: 1. Resident #5 had diagnoses of Hypertension, Congestive Heart Failure, Diabetes Mellitus, Acute/Chronic Respiratory Failure and Cognitive Communicate Deficit. A Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 7/8/15 documented the resident scored 14 (13-15 indicates cognitively intact) on a Brief Interview for Mental Status, required extensive assistance of 2 persons for bed mobility and	F 282		

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transfers and required extensive assistance of 1 person for dressing.

a. A Physician Order dated 7/31/15 documented, "...Compression Stocking to Lower Extremities..."

b. The September 2015 Medication Administration Record (MAR) documented "...Compression Stocking to Lower Extremities ..." The MAR was initialed by nurses three times daily at 6:30 a.m., 2:30 p.m. and 10:30 p.m., from 9/1/15 through 9/16/15.

c. On 9/14/15 at 1:08 p.m., the resident was sitting in a wheelchair in his room. There were no compression stockings in place on the resident's lower extremities. His legs were edematous. The resident was asked if he ever wore his compression stockings and he stated, "sometimes they put them on me; but most of the time they don't."

d. On 9/15/15 at 10:50 a.m., the resident was sitting in a wheelchair in the hallway. There were no compression stockings in place on the resident's lower extremities.

e. On 9/15/15 at 12:05 p.m., the resident was sitting in a wheelchair in his room. There were no compression stockings in place on the resident's lower extremities.

f. On 9/15/15 at 2:40 p.m., the resident was in bed sleeping. His lower extremities were uncovered. There were no compression stockings in place on the resident's lower extremities.

g. On 9/16/15 at 8:30 a.m., the resident was in

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F 282	Continued From page 5 bed sleeping. He was lying on his left side. His legs were uncovered. There were no compression stockings in place on the resident's lower extremities. h. On 9/16/15 at 11:18 a.m., Licensed Practical Nurse (LPN) #2 was asked about Resident #5's order for compression stockings. LPN #2 was then shown the resident's MAR and was asked to verify her initials, indicating the resident was wearing compression stockings on 9/15/15 [during her shift] and today [9/16/15]. LPN #2 stated, "I thought that I called myself looking at the compression stockings when I signed the MAR; I do not know what happened ... the night shift usually puts them on and removes them in the evening."	F 282		
F 309 SS=E	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure a urinary catheter was consistently secured to prevent potential trauma to the insertion site or bladder for 1 (Resident #6) of 3 (Residents #2, #5, and #6) case mix residents who had urinary catheters.	F 309		

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The facility failed to ensure necessary care and services were provided for an incontinent male resident, by failing to ensure the foreskin of the resident's penis was returned to its natural position after being retracted by staff for incontinent care, to prevent potential pain or restriction of blood flow for 1 (Resident #13) of 3 (Residents #6, #7, and # 13) male case mix residents who were incontinent and uncircumcised.

These failed practices had the potential to affect 13 residents who had urinary catheters, as documented on the Resident Census and Conditions of Residents form dated 9/14/15 and 8 male residents who were incontinent and uncircumcised, according to a list provided by the Director of Nursing (DON) on 9/17/15 at 8:45 a.m. The findings are:

1. Resident #6 had diagnoses of Septicemia, Urinary Tract Infection and Urinary Obstruction. The Quarterly Minimum Data Set with an Assessment Reference Date of 8/24/15 documented the resident scored 8 (8-12 indicates moderately impaired) on a Brief Interview for Mental Status, required extensive assistance of 1 person for toilet use and had an indwelling catheter.

a. The Care Plan dated 6/3/15 documented, " ...Problem: Supra Pubic cath [catheter] care every day ... I have a urinary catheter: provide cath care."

b. A physician order dated 8/11/15 documented, "Stat lock to secure Foley [catheter] and change as needed."

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c. The September 2015 Treatment Administration Record (TAR) documented, "...Stat-lock to secure Foley and change as needed ..."

d. On 9/16/15 at 9:05 a.m., Certified Nursing Assistant (CNA) #2 was in the resident's room assisting him to prepare items for his shower. The CNA assisted the resident to undress and transfer to the shower chair. The resident's supra pubic catheter tubing was not secured in place with a stat-lock or any other device, to prevent potential pulling or trauma.

e. On 9/16/15 at 10:10 a.m., as the resident sat in the shower; there was no stat lock in place to secure the catheter tubing.

At 11:00 a.m., Licensed Practical Nurse (LPN) #3 was asked, "Is [Resident #6] supposed to have a stat lock to secure his supra pubic catheter?" LPN #3 stated, "Yes." LPN #3 was asked, "Do you know why he [Resident #6] was not wearing a stat lock when he was brought to the shower." LPN #3 stated, "I don't know. It probably came off, or he might have refused it, or he didn't have one, but I will put one on him later."

f. On 9/16/15 at 2:00 p.m., the resident was in his wheelchair in the hallway. He was asked if his catheter insertion site ever gave him problems. He stated, "Yes. In fact that area is hurting now (pointed to the insertion site)." He was asked if his tubing was secured with a stat-lock or other device. He stated, "No, not that I know of."

g. On 9/17/16 at 12:20 p.m., the Director of Nursing (DON) was asked, "Whose responsibility is it to make sure a stat-lock is in place?" The DON stated, "The CNAs are supposed to make

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rounds, and that is one of the things they check".

2. Resident #13 had diagnoses of Cardiovascular Accident, Hypertension, and Convulsions. The Minimum Data Set with an Assessment Reference Date of 7/1/15 documented the resident was moderately impaired in cognitive skills for daily decision making per a Staff Assessment for Mental Status, was totally dependent on the assistance of 1 person for toileting, personal hygiene and bathing and was always incontinent of bowel and bladder.

a. The Care Plan dated 11/6/14 documented, " ...Problem: I need total care with my activities of daily living (ADLs) ... Approaches: ...I am incontinent of urine; I need you to provide peri care as needed... I am incontinent of bowel; document movements and keep me clean and dry please..."

b. On 9/15/15 at 2:40 p.m., Certified Nursing Assistant (CNA) #1 provided incontinent care for the resident who had been incontinent of urine. CNA #1 retracted the resident's foreskin and cleansed his urinary meatus. After cleansing, the CNA dried the area and, without returning the resident's foreskin to its natural position, continued with incontinent care.

The CNA was asked, "What is the standard for incontinent care for an uncircumcised male." CNA#1 stated, "You pull back the skin clean the head of the penis and wipe downward, and I guess that is all." The CNA was asked, "What should you do when finished cleansing the penis; do you need to replace the skin back over the penis." CNA stated, "No, I think that is all that you do".

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F 309	Continued From page 9 c. On 9/15/15 at 3:00 p.m., the DON was asked, "What is your facility and CNA training in regards to incontinent care of the uncircumcised male resident?" The DON stated, "You pull back the foreskin, cleanse area around that, and then you pull back the foreskin".	F 309		
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure 1 (Hall 200) of 5 halls was free of clutter and was passable for self-mobile residents to prevent potential injury from becoming entangled in equipment and to allow for unimpeded egress from the facility in the event of a fire. The facility also failed to ensure the door to the medication room was locked when unattended by staff, to prevent potential access / ingestion of medications by cognitively impaired, self-mobile residents on 1 (Hall 500) of 5 halls. These failed practices had the potential to affect 41 self-mobile residents who resided on the 200 Hall and 4 cognitively impaired self-mobile residents who resided on the 500 Hall according to lists provided by the Director of Nursing on 9/17/15 at 8:45 a.m. The findings are:	F 323		

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1. On 9/15/15 at 11:25 a.m., on the 200 hall, a shower gurney was parked against the Western wall. Directly across from the shower bed, a Hoyer lift was parked against the Eastern wall and a two-bin dirty laundry receptacle was parked in front of the lift. There was approximately

a. On 9/15/15 at 11:28 a.m., a non-case mix resident was propelling himself in a wheelchair down the 200 hall. As the resident attempted to navigate between the equipment on both sides of the hallway, he attempted to push a shower gurney out of his way. As the resident propelled forward, the wheel of his wheelchair got caught on a wheel of the Hoyer-lift. The resident backed up twice to attempt to maneuver around the lift wheel. As CNA staff walked by, he was told "just turn around and go back the other way". After a CNA staff member disengaged the resident's wheelchair from the Hoyer lift, the resident turned around and went the other direction.

b. On 9/15/15 at 11:30 a.m., a non-case mix resident in an electric wheelchair was attempting to navigate between the equipment on the 200 hall and had to back up twice to get the wheelchair through the area. The wheelchair bumped into the shower gurney and Hoyer lift as the resident passed between the equipment.

c. On 9/15/15 at 11:45a.m., a non-case mix resident in a wheelchair was attempting to wheel himself between the equipment parked on both sides of the 200 Hall. The resident ran into the shower gurney, backed up, then reattempted to move forward. The wheel of his wheelchair then became caught in the Hoyer lift wheels. The resident made multiple attempts to untangle the

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wheels. Two staff members passed the resident in the hall and, as they passed, the resident stated, "I can't get by." Registered Nurse (RN) #2 assisted the resident to untangle the wheels of his wheelchair from the wheel of the mechanical lift, then pushed the resident's wheelchair to the dining room for lunch.

d. On 9/15/15 at 11:50 a.m., RN #2 returned to the 200 hall and moved the shower gurney down the hallway. RN #2 then left the shower gurney between the fire doors on the eastern wall; preventing full closer in the event of a fire.

e. on 9/17/15 at 10:20 a.m., RN #2 was asked, "What is the facility policy for equipment placed in the hallway?" RN #2 stated, "You should place the equipment to one side of the hall, so residents can get through, especially residents walking down the hall." When asked if nursing staff is aware of facility policy regarding equipment placement in the hall ways she stated, "Yes, I guess they just get busy".

2. On 9/14/15 at 5:30 p.m., the door to the medication room on 500 Hall had been left open. There was no staff within sight of the open door. Licensed Practical Nurse (LPN) #1 assigned to the 500 Hall was passing medications and did not have the medication room door in her line of sight.

a. On 9/14/15 at 6:05 p.m., as Licensed Practical Nurse (LPN) #1 continued to pass medications, the surveyor asked her if the door to the medication room should be left open. LPN #1 stated, "It should be locked at all times. I did not know that it was open; the hall supervisor must have gone in there to get her personal things and

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F 323	Continued From page 12 then left the door open." LPN #1 then walked to the medication room and closed the door. At 6:07 p.m., LPN #1 accompanied the surveyor into the 500 Hall medication room (which had previously been left open and unattended by staff) to determine if there were items in the room that would be hazardous if accessed or ingested by a resident. There were bubble packs of discontinued medications on a shelf in an unlocked cupboard and vials of Insulin and intravenous medications in the refrigerator, which was also unlocked.	F 323		
F 333 SS=E	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure physician orders for medications were followed to prevent significant medication errors and potential complications for 1 (Resident #8) of 2 (Residents #7 and #8) case mix residents who had physician orders for Flovent inhaler. This failed practice had the potential to affect 4 residents with physician orders for Flovent, as documented on a list provided by the Director of Nursing (DON) on 9/17/15 at 8:45 a.m. The findings are: 1. Resident #8 had a diagnosis of Chronic Obstructive Pulmonary Disease The Admission Minimum Data Set with an Assessment Reference date of 8/10/15 documented the	F 333		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045357	A. BUILDING _____ B. WING _____	09/17/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER HEALTH AND REHABILITATION, LLC	3600 RICHARDS ROAD NORTH LITTLE ROCK, AR 72117

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 333	Continued From page 13	F 333		

resident scored 15 (13-15 indicates cognitively intact) on a Brief Interview for Mental Status (BIMS).

a. A Hospital Summary sheet dated 8/28/15 documented, "Fluticasone 110 mcg/actuation [micrograms per actuation] inhaler. Dose:1 puff. Inhale 1 puff into the lungs 2 (two) times daily."

b. A physician's admission order sheet dated 8/28/15 documented, "Flovent HFA [hydrofluoroalkane (propellent)] 110 mcg 1 puff into lungs BID [twice daily]".

c. As of 9/15/15, the August 2015 and September 2015 Medication Administration Records (MARs) had no documentation to indicate this medication was administered to the resident as ordered from 8/29/15 through 9/15/15, for a total of 20 missed doses. The physician order for Flovent was not documented on the MARs.

d. On 9/15/15 at 2:49 p.m., Registered Nurse (RN) #1 was asked if the Flovent had been administered to the resident as ordered, from 8/29/15 through 9/15/15. She stated, "I do not know what happened. [Resident #8] was admitted to 200 Hall; it [error] must have happened over there." The RN stated [Resident #8] was then transferred to the 500 hall, and it looks like it was missed there."

e. On 9/15/15 at 2:52 p.m., Licensed Practical Nurse (LPN) #2 was asked about the Flovent order for Resident #8. LPN #2 stated, "There is not an order for Flovent on the MAR. She [Resident #8] does not have an order to give Flovent."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045357	A. BUILDING _____ B. WING _____	09/17/2015

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F 333	Continued From page 14 f. On 9/15/15 at 2:56 p.m., the Assistant Director of Nursing (ADON) was asked about the Flovent order for Resident #8. She stated, "Orders are checked when the resident is admitted, then I double-check the orders for accuracy. It must have gone through both of them [checks]. It was missed."	F 333		