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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045337	A. Building B. Wing	02/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Heather Manor Nursing and Rehabilitation Center	400 West 23rd Street Hope, AR 71801

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on observations, interviews, record review, and facility policy review, the facility failed to ensure privacy was protected, and dignity was maintained for 1 (Resident #70) of 1 sample resident observed for incontinence care. The findings include: A review of the significant change Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 11/08/2024, revealed Resident #70 had a Brief Interview of Mental Status (BIMS) score of 15 indicating the resident was cognitively intact. Resident #70 was occasionally incontinent of bowel and bladder. A review of the Plan of Care for Resident #70, revision date 07/05/2024, revealed Resident #70 had occasional incontinent episodes of bladder. On 02/04/25 at 2:24 PM, Surveyor observed Certified Nursing Assistant (CNA) #4 provide incontinence care to Resident #70 with the blinds raised halfway and open at the top. The window was facing the parking lot to the front of the building, where the facility entrance was located. The surveyor observed several cars in the lot outside the window. CNA #4 removed the resident ' s brief while the resident was positioned in a manner their buttocks and genital area were clearly visible from the window. On 02/04/25 at 2:30 PM, CNA #4 was interviewed regarding the incident and stated she should have closed the blinds prior to providing incontinence care to Resident #70. On 02/05/25 at 9:19 AM, During an interview, the Director of Nursing (DON) stated staff should close the door, pull the curtain, and close the blinds to provide privacy and maintain the residents' dignity. The DON stated if the blinds were raised and open to the front park lot while a resident was receiving incontinence care that could be a dignity issue. A copy of the facility policy titled Resident Rights noted that every resident in this facility has the right to be treated with consideration, respect, and full recognition of dignity and individuality. Also, privacy during treatment and care of personal needs.

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, record review, and facility document review, it was determined the facility failed to ensure written notification provided to the resident and/or the resident's representative of transfer/discharge to the hospital included all the required information for 3 (Resident #69, Resident #76, and Resident #49) out of 3 sampled residents reviewed for hospitalizations. The findings include: The quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 11/20/2024, revealed Resident #69 had a Brief Interview for Mental Status (BIMS) of 15 (indicating the resident was cognitively intact), and diagnoses that included end-stage renal disease (Kidney Failure), seizure disorder, and diabetes (abnormal blood sugar). A review of the facility document titled Emergency Transfers from Facility indicated Resident #69 was transferred to the hospital on 4 occasions: a. 10/29/2024 to 11/04/2025 b. 12/18/2024 to 12/21/2024 c. 12/28/2024 to 12/30/2024 d. 01/08/2025 to 01/11/2025 On the morning of 02/05/2025, the Administrator was asked to provide the notices of transfer for the hospitalizations listed above. On 02/05/2025 at noon, the Administrator provided a letter of transfer for each hospitalization. A review of the letter revealed not all the required information had been given to the Resident and/or Resident's representative, as required for a hospitalization or Emergency Department visit. The two missing elements were the appeals process and how to notify the Ombudsman, as described below. 1. A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request. (continued on next page)

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F 0623

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

2. The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman

On 02/05/25 at 2:20 PM, the Administrator was interviewed regarding the letter of Transfer given to the Resident. The Administrator stated there was no additional information given to the Resident and/or Representative, only the documents previously provided.

On 02/06/25 at 9:30 AM, the Administrator was interviewed regarding the missing information (appeals process and how to notify the Ombudsman, as described above) given in writing to a representative and/or Resident upon transfer from the facility. The Administrator was not able to demonstrate that the missing information was included.

On 02/06/2025 at 3:40 PM, during an interview with the Director of Nursing (DON) and the Administrator, the Administrator had no additional comments regarding the missing information on the forms and stated understanding regarding the need for the information for the Resident's ongoing care.

A review of the discharge Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 12/18/2024 indicated Resident #76 ' s active diagnoses included dementia with other behavior disturbances, infection/inflammatory reaction due to internal right knee prosthesis, encephalopathy, presence of right artificial knee joint, and had a Brief Interview for Mental Status (BIMS) score of 14 (indicated cognitively intact).

On 02/06/2025, the Administrator provided a copy of facility document titled Emergency Transfers from Facility dated December 2024, which revealed Resident #76 was transferred to hospital for behaviors on 12/18/2024. The Administrator also provided a copy of a facility letter dated 12/18/2024, indicating Resident #76 was transferred to the hospital for behavioral symptoms. A review of the letter revealed not all the required information had been given to the Resident and/or Resident's representative, as required for a hospitalization or Emergency Department visit. The two missing elements, in summary, are the appeals process and how to notify the Ombudsman, as described below.

1. A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request.

2. The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman

The admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 03/12/2024, indicated Resident #49 had diagnoses of Alzheimer's disease, non-Alzheimer's dementia, anxiety disorder and had a Brief Interview for Mental Status (BIMS) score of 12 (indicated moderately impaired).

On 02/06/2025, the Administrator provided copy of a facility document titled Emergency Transfers from Facility dated September 2024, which revealed Resident #49 transferred to the hospital on [DATE], for abdominal pain, nausea and vomiting and low blood pressure with a date of return to facility of 10/03/2024.

On 2/07/2025, the Administrator provided a copy of a facility letter dated 09/10/2024, that indicated Resident #49 was transferred to the hospital for abdominal pain, nausea and vomiting and low blood pressure. Review of the letter revealed not all the required information had been given to

(continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #49 and/or Resident's representative, as required for a hospitalization or Emergency Department visit. The two missing elements, in summary, are the appeals process and how to notify the Ombudsman, as described below. 1. A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request. 2. The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, record review, facility document review, and facility policy review, it was determined the facility failed to ensure a written bed hold notification was provided prior to hospital transfer for 1 (Resident #76) of 7 sample residents reviewed for hospitalization. The findings include: 1. A review of the Annual Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 11/28/2024, indicated Resident #76 had diagnoses of Dementia with other behavior disturbances, encephalopathy, presence of right artificial knee joint and a Brief Interview for Mental Status (BIMS) score of 14 (13-15 indicates cognitively intact). a. A facility letter dated 12/18/2024, indicated Resident #76 was transferred to [named Hospital] for behavior symptoms. b. A review of Resident #76 ' s medical record revealed no documentation of bed hold notification was provided to resident or the resident representative at time of Resident #76 ' s transfer to the hospital on [DATE]. c. On 02/06/2025 at 11:35 AM, a bed hold policy was requested and received from the administrator. The facility policy titled, Bed-Hold Policy and Return, dated 11-2018, was reviewed and indicated the bed hold policy will be provided to resident or resident representative before the facility transfers the resident to a hospital. The last paragraph indicates the facility will contact the resident/resident representative on the next business day after the resident leaves the facility to review any bed-hold. The administrator indicated the Business Office Manager (BOM) was responsible to send the notice of bed hold to the resident/resident representative. d. 02/06/2025 at 12:07 PM, during an interview with the Business office Manager (BOM) she indicated she was responsible for sending the notice of bed-hold. The BOM indicated Resident #76 did not receive notice of bed hold because the resident was in a skilled bed and the facility does not hold skilled beds after midnight. The BOM verified no notice of bed hold policy was sent to resident/resident representative.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. Based on record review, interview, and facility policy review, the facility failed to ensure gradual psychotropic (antipsychotic) dose reductions were addressed and (anti-anxiety) dose reductions (GDR) were attempted in the absence of a physician's documented evaluation of the specific risks versus benefits of continuing the as needed (PRN) medication past 14 days and a documented explanation as to why a dose reduction attempt would be contraindicated, in order to ascertain the smallest effective dose and minimize the potential for adverse drug effects for 1 (Resident # 11) of 5 residents reviewed for unnecessary medications. The findings include: A review of the admission Minimum Data Set (MDS) with the Assessment Reference Date (ARD) of 10/31/24, revealed Resident #11 had a Brief Interview of Mental Status (BIMS) score of 12, indicating moderately impaired cognition. Review of a Plan of Care for Resident #11 with a revision date of 01/09/2025, revealed Resident #11 used the psychotropic medication [A brand name antipsychotic medication used to treat major depressive disorder, schizophrenia in adults and children aged 13 years and older, and agitation associated with dementia due to Alzheimer's disease] related to behavior management. Resident #11 used anti-anxiety medications [A brand name medication used to treat anxiety disorders] related to anxiety disorder. When reviewed on 02/05/25, a PRN [as needed] Psychotropic Use form dated 11/03/24 noted Resident #11 had had an active order for [A name brand medication used to treat anxiety disorders] 0.5mg Q [every] 6 H [hours] PRN [as needed] for anxiety since 10/25/24. CMS [Centers for Medicare and Medicaid Services] limits the PRN use of [A brand name medication used to treat anxiety disorders] to treat anxiety to 14 days initially. After 14 days, CMS requires a new PRN order to be written. The new PRN order must specify a valid clinical rationale for continuation and a specific duration of therapy recommended not to exceed 60 days. Please clarify. A review of an incomplete Request for reduction of Antipsychotic Medication form dated 11/15/2024, noted Resident #11 was admitted with order for [A brand name antipsychotic medication used to treat major depressive disorder, schizophrenia in adults and children aged 13 years and older, and agitation associated with dementia due to Alzheimer's disease] 2mg [milligrams] QHS [every bedtime] for schizophrenia since 10/23/24 and stipulated the need to clarify diagnosis (DX). In the absence of approved DX (diagnosis), the facility needed to reduce [A brand name antipsychotic medication used to treat major depressive disorder, schizophrenia in adults and children aged 13 years and older, and agitation associated with dementia due to Alzheimer's disease] to 1milligram (mg). This correction was not found in the resident ' s health record. On 02/05/25 at 4:26 PM, the Director of Nursing (DON) stated the facility did not have documentation completed by the prescribing physician providing a rationale why the as needed antianxiety medication should be continued past 14 days. The DON stated the facility did not have documentation noting an approved diagnosis or reduction was completed for the suggested antipsychotic Gradual Dose Reduction (GDR), because it was not done. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of policy titled Psychotropic Medications noted it is policy of this facility to ensure that residents who have not used psychotropic medications are not given these medications unless the medication is necessary to treat a specific condition, as diagnosed and documented in the resident's clinical record

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observations, and facility policy review, the facility failed to ensure medication was properly stored to prevent unauthorized individuals from having access. The findings include: On 2/04/25 at 9:05 AM, this surveyor observed Licensed Practical Nurse (LPN) #3 walk down the hall and enter a resident's room. This surveyor noted there was a vial of insulin, a tube of wound gel, and a plastic cup which contained a clear liquid on top of the medication cart left unattended in the hallway. On 02/04/25 at 9:08 AM, this surveyor observed LPN #3 walk down the hall and enter a resident's room. This surveyor noted there was a vial of insulin, a tube of wound gel, and an unlabeled plastic cup with a clear liquid inside on top of the unattended medication cart. On 02/04/25 at 9:44 AM, this surveyor observed LPN #3 administer the contents in the plastic cup to a resident. LPN #3 stated he had pre-prepared a resident ' s [laxative solution mediation name] which was in the plastic cup. LPN #3 stated it was not standard practice to pre-prepare medications, but the [laxative solution medication name] dissolved better when pre-prepared. LPN #3 stated the medications should not have been left on top of the medication cart unattended. On 02/05/25 at 9:19 AM, the Director of Nursing (DON) confirmed that medications should not be left unattended in areas accessible to residents and visitors because anyone could get them. A policy titled Medication Storage in the Facility effective date 01/01/15, noted medications and biologicals are stored safely, securely, and properly accessible only to licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer medications.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on observation, record review, interview and policy review the facility failed to ensure staff used infection control measures while providing care to 1 (Resident #70) of 1 sampled resident observed for incontinence care, and staff donned the proper Personal Protective Equipment (PPE) prior to providing high contact care to 2 (Resident #11, #64) of 2 sampled residents on Enhanced Barrier Precautions (EBP), and proper hand hygiene was followed during wound care for 1 resident (Resident #53) of 3 sampled residents reviewed for pressure ulcer care. The findings include: 1. A review of the admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 10/31/2024, revealed Resident #11 had a Brief Interview of Mental Status (BIMS) score of 12 indicating moderate cognitive impairment. a. Review of a Plan of Care for Resident #11 with a revision date of 01/10/2025, revealed Resident #11 had an indwelling catheter due to a terminal condition and was on enhanced barrier precautions related to the indwelling catheter. b. On 02/03/2025 at 11:35 AM, this surveyor observed Certified Nursing Assistant (CNA) #1 and CNA #2 transfer Resident #11 from the bed to the wheelchair using the mechanical lift. This surveyor noted neither of the two CNAs had gowns in place. c. On 02/03/2025 at 11:45 AM, CNA #2 stated she had checked Resident #11 ' s brief and catheter wearing only gloves. CNA #2 stated Resident #11 should be on EBP for the catheter, but there was no sign posted. d. On 02/04/2025 at 10:40 AM, the Director of Nursing (DON) stated We just put that catheter back in Friday [referring to Resident #11]. First, Enhance Barrier Precautions were a thing, then it was not, so are we back to it being a thing? 2. A review of the admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 01/20/2025, revealed Resident #64 had a Brief Interview of Mental Status (BIMS) score of 14, indicating Resident #64 was cognitively intact. a. A review of the Plan of Care for Resident #64 with a revision date of 01/27/2025, revealed Resident #64 had a gastrostomy tube related to dysphagia and Resident #64 was on Enhanced Barrier Precautions (EBP) related to Percutaneous Endoscopic Gastrostomy (PEG) tube. b. On 02/04/2025 at 9:40 AM, this surveyor observed Licensed Practical Nurse (LPN) #3 at the bedside administering medication to Resident #64 via PEG tube. This surveyor noted LPN #3 was not wearing a gown. c. On 02/04/2025 at 10:03 AM, LPN #3 stated he should have applied proper PPE when he administered medications to Resident #64 via PEG. LPN #3 stated there was no signage posted on Resident #64's door to alert staff the resident was on EBP. d. On 02/05/2025 at 9:19 AM, during an interview with the DON, she stated signage posted on the exterior door alert staff to use proper Personal Protective Equipment (PPE) prior to providing care to (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the residents on enhanced barrier precaution. e. The facility did not have a policy on Enhanced Barrier Precautions. 3. A review of the significant change Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 11/08/2024, revealed Resident #70 had a Brief Interview of Mental Status (BIMS) score of 15 indicating Resident #70 was cognitively intact, and Resident #70 was occasionally incontinent of bowel and bladder. a. A review of the Plan of Care for Resident #70, revision date 07/05/2024, revealed Resident #70 had occasional incontinent episodes of bladder. b. On 02/04/2025 at 2:24 PM, this surveyor observed Certified Nursing Assistant (CNA) #4 throw a dirty incontinence brief on the floor. c. A facility policy titled Infection Prevention and Control Program noted standard precautions will be used in the care of all residents regardless of their diagnoses, or suspected or confirmed infection status. d. A facility policy titled Perineal/Incontinence Care noted, place two (2) open bags at the foot of the bed (for soiled linens and trash). 4.The Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 11/02/2024, indicated Resident #53 had a Brief Interview for Mental Status score of 5, which indicates severe cognitive impairment, and Resident #53 had diagnoses of peripheral vascular disease (impaired blood flow to the legs), wound infection, and diabetes (abnormal blood sugar). a. On 02/15/2025 at 9:58 AM, the Treatment Nurse was observed while changing the dressing for a pressure ulcer to the sacral area (at the base of the small of the back and the top/middle of the buttocks) for Resident #53. Resident #53's room was observed to have Enhanced Barrier Precautions (EBP) signage on the door with a caddy supplied with Personal Protective Equipment (PPE.) Steps in the process observed were as follows: 1) The nurse had an appropriate gown on at the start of the observation. 2) The nurse performed hand hygiene with soap and water and put on gloves. 3) Resident positioned onto right side 4) Incontinence brief pulled down 5) Mud-consistency brown stool noted 6) Sacral dressing removed 7) Gloves changed without hand hygiene performed 8) Wound cleaned from center of wound toward rectum (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	9) Gloves changed without hand hygiene performed 10) New dressing applied to coccyx b. On 02/05/2025 at 3:00 PM, a handwashing policy was requested from the MDS Coordinator and provided. Upon review of the policy by this surveyor, there was no information in the body of the document provided to address hand hygiene during wound care. c. On 02/06/2025 at 10:10 AM, the Treatment Nurse was interviewed regarding hand hygiene and aseptic technique during wound care. The Treatment Nurse described that she did not perform hand hygiene in between changing gloves, and that hand sanitizer should have been used because it was an important step in reducing the chance of spreading infection. d. On 02/06/2025 at 10:50 AM, the Director of Nursing (DON) was interviewed regarding hand hygiene and aseptic technique for wound care. The steps listed above were reviewed, and any available additional documentation was requested. The DON provided a document titled Dressing Change Using Aseptic Technique. The steps listed indicated that hand hygiene with alcohol gel was to be done prior to putting on clean gloves, after removing dirty gloves during the dressing change. The DON was asked the importance of performing hand hygiene during a dressing change and changing gloves and stated, You should use hand sanitizer to make sure hands are clean in between changing gloves.