

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045436	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/17/2025
NAME OF PROVIDER OR SUPPLIER Presbyterian Village, Inc		STREET ADDRESS, CITY, STATE, ZIP CODE 500 Brookside Drive Little Rock, AR 72205	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>Based on observation, interviews, and record review, the facility failed to ensure a physician's order for applying compression stockings/leg wraps was being followed for 1 (Resident #40) of 1 resident reviewed requiring compression stocking or legs wraps.</p> <p>The findings include:</p> <p>A review of a Resident Summary indicated the facility admitted Resident #40 with a diagnosis of hypertension (high blood pressure) that included edema (swelling).</p> <p>The quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 01/31/2025, revealed Resident #40 had a Brief Interview for Mental Status (BIMS) of 8, which indicated the resident was moderately impaired for their daily decision making.</p> <p>A review Resident #40's Physician Orders for the month of 04/2025, revealed an order dated 01/31/2024, to apply compression stockings daily prior to resident getting out of bed for edema. Another order dated 10/16/2024, indicated to wrap both legs from toes to knees daily for edema.</p> <p>A review of Resident #40's medications listed on Physician Orders revealed an order dated 03/13/2025, for a water pill [generic diuretic] to decrease edema. Review of Resident #40's Physician Orders updated on 04/16/2025, revealed that the physician prescribed another diuretic [name brand diuretic] to help decrease the edema.</p> <p>A review of Resident #40's Care Plan dated 02/07/2025, revealed interventions to apply compression stockings and to notify the doctor if edema increases.</p> <p>On 04/14/25 11:30 AM, Resident #40 was observed sitting in their recliner with legs elevated. Edema was noted to both legs and no compression stockings or wraps were on the resident.</p> <p>On 04/15/25 12:33 PM, Resident #40 was observed sitting in their recliner with legs elevated. Edema was noted to both legs and no compression stockings or wraps were on the resident.</p> <p>On 04/16/25 8:35 AM, Resident #40 was observed sitting in their recliner with legs elevated. Edema was noted to both legs and no compression stockings or wraps were on the resident.</p> <p>On 4/16/2025 at 7:37 AM, during an interview, Resident #40 stated their legs were hurting due to the swelling. Resident #40 was asked if anyone had wrapped their legs or applied compression stockings. The resident stated it had been a few weeks. Resident #40 stated they would like for their legs to either be wrapped or have the compression stockings applied.</p> <p>(continued on next page)</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 04/16/25 at 7:49 AM, Certified Nursing Assistant (CNA) #2 stated she had applied Resident #40's compression stockings on 04/03/2025. CNA# 2 stated Resident #40 requested later during the day to have the compression stockings removed. CNA# 2 stated she removed them, and she reported it to the charge nurse but that it was not documented anywhere. CNA #2 was asked if she had asked Resident #40 if they wanted the compression stockings on and CNA#2 stated she had not.</p> <p>During an interview on 04/15/2025 at 8:00 AM, with Restorative Certified Nursing Assistant (RCNA) # 6, she was asked if she had ever applied or asked Resident #40 about applying the compression stockings. RCNA#6 said she had not.</p> <p>During an interview on 04/16/25 at 8:28 AM, Licensed Practical Nurse, (LPN) #3 reviewed the Medication Administration Record (MAR) for Resident #40 to see if there was an order for the compression stockings or the wrap. She stated there was no order, therefore she would not be the one to wrap them. LPN#3 stated an order for compression stockings or leg wraps would be on the Treatment Administration Record (TAR) and the treatment nurse would be responsible for ensuring the stockings or wraps were applied.</p> <p>On 04/16/25 at 8:35 AM, during an interview with LPN #1, she reviewed the TAR and said there were no orders for compression stocking or leg wraps. LPN#1 stated the orders would not be on the TAR. LPN #1 reviewed the Physician Orders for Resident #40 and stated the compression stockings or wraps should be applied. At 8:45 AM, LPN #1 entered Resident #40's room and asked the resident if anyone had offered to apply the compression stocking or wraps. Resident #40 said no one had attempted but the resident would allow the wraps to be applied. LPN#1 stated she would notify the doctor about the legs swelling.</p> <p>On 04/16/25 at 9:45 AM, during an interview with the Director of Nursing (DON) she stated that the orders for the compression stockings and the wrap were overlooked and were entered as an ancillary order rather than a doctor's order. The DON stated the order should be on the MAR, and the nurses should apply them daily.</p> <p>On 04/16/25 at 9:53 AM, during an interview with the Medical Director (MD), she stated the compression stockings or wraps should be applied or offered daily to Resident #40 but if the resident refused, staff should educate the resident and offer again later. The MD stated she believed nurses should have a tracking record and interventions for treatments ordered. The MD stated she was not aware that the wraps or compression stockings had not been applied or offered. The Medical Director ordered for the resident to receive a fluid pill [Name brand diuretic] to help decrease the edema.</p> <p>On 04/16/25 at 10:36 AM, during an interview with the DON, this surveyor requested copy of the facility 's policy on following physician orders and for applying compression stockings/wraps. The DON presented a copy of a policy titled Antiembolytic Stockings Policy and Procedure. The policy indicated the purpose of the policy was to provide support for lower extremities, to aid return circulation from lower extremities, to prevent embolus (blood clots) formation, to reduce pain, and to reduce edema.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p>Based on observation, interview, facility policy review, and document review, it was determined that the facility failed to ensure staff performed hand hygiene while feeding dependent residents to prevent the spread of infection and cross contamination. This failed practice had the potential to spread infection to 4 residents (Resident #18, #21, #32, and #37) of 4 sampled residents observed for dependent dining.</p> <p>The findings include:</p> <p>A review of a facility policy titled, Hand Hygiene Policy and Procedure undocumented date, revealed staff should always perform hand hygiene after contact with a resident's mucous membranes, body fluids or excretions and to cleanse the hands between residents direct contact.</p> <p>A review of a facility policy titled, Infection Prevention and Control Program copyright date 2024, revealed hand hygiene shall be performed in accordance with our facility's established hand hygiene procedures.</p> <p>A review of the in-service titled, Disinfection of Hands, dated 01/04/25, revealed all personnel should stop and disinfect hands before passing out the next person's food and drink and may use hand sanitizer x3 (3 times), then use soap and water.</p> <p>During a 40-minute observation on 04/14/25 at 12:34 PM, Activity Director/Certified Nursing Assistant (CNA #4) was assisting with meals for (4) four dependent resident diners; Residents #18, #21, #32, and #37, touched dirty napkins after CNA #4 wiped the faces of Resident #37 and Resident #18, and touched the legs of Resident #32 to wake the resident up to take a bite, without performing hand hygiene between each resident, then continued to feed each resident.</p> <p>During an interview with CNA #4 on 04/14/25 at 1:17 PM, CNA #4 stated she was only supposed to use hand hygiene when she started and finished feeding the residents. CNA #4 stated, I cross contaminated by not using hand sanitizer and could spread infection to other residents. CNA #4 revealed she had not been in-serviced on hand hygiene for feeding residents.</p> <p>During an interview with CNA #5 on 04/14/25 at 1:21 PM, CNA #5 stated, Staff should use</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>hand sanitizer upon entering the room, in between each resident, after touching things or resident, and when finished to prevent spreading infection. CNA#5 revealed she had not been in-serviced at this facility, but she had experience from a previous position.</p> <p>During an interview with the Infection Preventionist Licensed Practical Nurse (LPN #1) on 4/15/25 at 10:19 AM, LPN #1 stated staff should sanitize their hands before they go in and when they leave from residents rooms, after wiping a resident's face and touching anything that could spread infection to other residents.</p> <p>A review of the in-service titled, Hand Hygiene, dated 04/16/25, revealed staff should use hand sanitizer before and after passing out resident meal trays and in between each tray.</p> <p>During an interview with the Medical Director (MD) 04/16/25 at 9:53 AM, the MD stated, Staff should perform hand hygiene at least 3 times with resident contact-before, during and after and if they touch anything else they need to hand hygiene again. She confirmed it was difficult during assist feeding of resident, but hand hygiene must be followed to prevent spread of infection while feeding multiple residents, especially if you were touching anything other than the spoon handle. She stated, By performing hand hygiene it prevents transmission of many diseases.</p> <p>During an interview with the Director of Nursing (DON) on 04/17/25 10:56 AM, the DON stated it was important for staff to use hand hygiene between residents to prevent spread of infection and it should be done between each resident while feeding residents especially if they touched the actual body. The DON stated competencies were done annually, on hire, and when the need arose.</p> <p>During an interview with the Administrator on 4/17/25 at 11:47 AM, the Administrator stated hand hygiene was important to do to prevent cross contamination, and must be done during assistive feeding, especially if touching anything other than spoon handles.</p>		