

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  045447	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  07/24/2025
NAME OF PROVIDER OR SUPPLIER  Greenhurst Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE  226 Skyler Drive Charleston, AR 72933	

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 0582</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered.</p> <p>Based on record review and interview, the facility failed to ensure an Advanced Beneficiary Notice (ABN) was provided within two business days and notification of their financial liability for care and services after the Medicare coverage was discontinued for one (Resident #4) of three residents reviewed for ABN notices.</p> <p>The findings include:</p> <p>A review of Resident #4's admission Record indicated the facility admitted the resident on 03/21/2025, with diagnoses which included vascular dementia with mild anxiety, stroke, prostate cancer, bone cancer, and personal history of transient ischemic attack.</p> <p>A review of Resident #4's quarterly Minimum Data Set with an Assessment Reference Date of 04/30/2024, revealed a Brief Interview for Mental Status score of 08, which indicated the resident had moderately impaired cognition.</p> <p>A review of Resident #4's Care Plan, with a revision date of 03/27/2025, revealed the resident had a stroke. The resident's Care Plan indicated a goal for Resident #4 to show improvement to maximum potential to perform activities of daily living.</p> <p>A review of Resident #4's Skilled Nursing Facility Beneficiary Notification Review Forms on 07/23/2025 at 10:55 AM, revealed the form had been signed by Resident #4's legal representative on 05/01/2025. The ABN revealed Resident #4 would be discharged on 05/01/2025.</p> <p>During an interview on 07/23/2025 at 11:04 AM, the Assistant Director of Nursing (ADON) stated he notified residents or residents' legal representatives at least two days before a resident was to be discharged. The ADON reported he spoke to Resident #4's legal representative by telephone two days before the facility was planning to discharge Resident #4 but had no documentation to verify the event. The ADON confirmed the ABN was signed on 05/01/2025, by Resident #4's legal representative. The ADON stated it was important to notify and provide the ABN to a resident or resident representative, prior to the discharge, so home health, supplies, or referrals could be made in a timely manner. He also stated the ABN gave the information to the residents and/or resident representatives in case they wished to appeal the discharge from a skilled nursing bed.</p> <p>During an interview on 07/23/2025 at 11:15 AM, the Director of Nursing (DON) stated the ADON was responsible for notifying the resident or resident's legal representative of the anticipated discharge from a skilled nursing bed and to complete the ABN. She verified the ABN was to be completed at least two days prior to the discharge. The DON verified Resident #4's ABN was signed by</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 0582</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>their legal representative on 05/01/2025, which was the same day as the resident's discharge from a skilled nursing bed. The DON reported Resident #4's legal representative was notified of the anticipated discharge two days prior to the discharge via telephone by the ADON but could not provide documentation to verify the event. The DON stated when the facility notified a resident or resident's representative by telephone the facility had a witness, and they would both sign the ABN verifying the event took place.</p> <p>During a phone interview on 07/23/2025 at 11:23 AM, Resident #4's legal representative reported they were not informed via telephone or in person prior to the resident's discharge. Resident #4's legal representative revealed they did get informed of the discharge from a skilled nursing bed back to a long-term care bed on 05/01/2025 and the representative came to the facility and signed the ABN. The resident's legal representative reported they were aware the discharge could have been happening soon, due to Resident #4 not participating with therapy, but was not made aware of a specific discharge date .</p> <p>During an interview on 07/24/2025 at 10:23 AM, the Medical Director verified the facility should notify residents and residents' legal representatives at least two days before discharge from a skilled nursing bed.</p> <p>During an interview on 07/24/2025 at 11:47 AM, the Administrator stated residents and/or the resident's legal representatives should be notified of a discharge from a skilled nursing bed and receive an ABN at least three days before the discharge, or when the facility made a determination of anticipated upcoming discharge before the discharge date . The Administrator stated the ABN made the resident or resident legal representative aware of the discharge and gave them the right to appeal the discharge if they decided to.</p> <p>The DON stated the facility did not have a policy related to ABNs.</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>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.</p> <p>Based on observation, record review, and interview, it was determined that the facility did not ensure medications were stored securely while the medication cart was left unattended, for two (Hall 100 and Hall 200) of four medication carts.</p> <p>The findings include:</p> <p>During an observation of medication administration on 07/23/2025 at 9:07 AM, Licensed Practical Nurse (LPN) #1 left the medication cart unattended and proceeded up the hall from the 200-hall dining room to the medication storage room at the front of the facility, out of the sight of this surveyor. The medications left unattended on top of the cart included partial blister packs each of a beta-blocker used to treat high blood pressure, an alpha-blocker used to treat high blood pressure, a diuretic used to treat fluid retention, an anti-diabetic medication, a mineral supplement used to lower potassium levels, and a steroid. There was also one partial bottle each of chewable aspirin, a multi-vitamin with minerals, and a probiotic supplement. At 9:12 AM, LPN #1 returned to the medication cart and confirmed all the medications should have been placed in the medication cart, and the cart should have been locked, before the LPN left the cart. LPN #1 indicated the medications were left unattended on the top of the cart, because the surveyor was standing there with the medications. LPN #1 stated they were trained to not leave the medications out, due to residents or visitors having access to medications, stating "that's my bad."</p> <p>During an observation of medication administration on 07/23/2025 11:51 AM, a partial bottle of iron was left unattended on top of the medication cart, while LPN #2 left the cart to give medications across the hall. LPN #2 was out of eyesight of the medication cart for approximately 81 seconds. LPN #2 stated they were trained to ensure all meds were stored in the cart, and the cart was to be locked when unattended.</p> <p>A review of a Med Pass Observation Report, dated 07/18/2025, revealed a check mark on the "Med" column, next to "Medications are not left on top of cart" with LPN #1's name and signature on the report.</p> <p>A review of a Med Pass Observation Report, dated 07/18/2025, revealed a check mark on the "Med" column, next to "Medications are not left on top of cart" with LPN #2's name at the top of the report.</p> <p>A review of an in-service titled Controlled Substance, Medication Administration, dated 05/12/2025, revealed LPN #1 and LPN #2's signatures of attendance. The training included medication storage, administration, and secure storage of narcotics.</p> <p>During an interview on 07/23/2025 at 2:08 PM, the Director of Nursing (DON) clarified the facility's policy and expectation was that medications were not to be left on top of the medication cart, when the cart was left unattended. She confirmed medications were to be secured inside the medication cart. The DON verified LPN #1 and LPN #2 were trained on 05/12/2025, on medication administration and storage, with medication administration audits completed on 07/18/2025 that included both LPN #1 and LPN #2.</p> <p>(continued on next page)</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 07/24/2025 at 10:24 AM, the Medical Director confirmed the expectation was that medications should be stored securely and away from non-licensed staff when unattended.</p> <p>During an interview on 07/24/2025 at 11:46 AM, the Administrator confirmed the expectation was that facility staff would follow the facility policies, and medications should be stored securely away from non-licensed staff, when unattended.</p> <p>A review of the "Medication Storage in the Facility" policy with an effective date of 01/01/2015, read, in part, medications were stored securely, only assessable to licensed nursing personnel or staff members lawfully authorized to administer medications.</p>		