

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENTIFICATION NUMBER 045140	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/26/2020
NAME OF PROVIDER OF SUPPLIER SEARCY HEALTHCARE LLC		STREET ADDRESS, CITY, STATE, ZIP 1205 SKYLINE DRIVE SEARCY, AR 72143	
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 0658 Level of harm - Minimal harm or potential for actual harm Residents Affected - Few	<p>Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Complaint # (AR 586) was substantiated, all or in part, with these findings. Based on record review and interview, the facility failed to ensure notification of the resident's demise was documented and available in the record to increase knowledge of the resident's status in accordance with acceptable standards of practice for 1 (Resident #1) of 1 sampled resident who expired in the facility. This failed practice had the potential to affect 8 residents who expired in the facility in the last 60 days, as documented on a list provided by the Administrator on [DATE] at 09:07 AM via email. The findings are: Resident #1 had [DIAGNOSES REDACTED]. a. The Care Plan dated [DATE] documented this resident had no plans to discharge, he is under Adult Protective Services (APS) custody. b. On [DATE] at 03:30 PM, the Resident's Profile information documented, the State Agency/Guardian/Responsible Party with phone numbers listed for the Office, Home and Mobile phone . c. On [DATE] at 04:00 PM, the Director of Nursing (DON) was asked, If a resident is a ward of the state, who do you notify when he/she expires? She stated, We notify the Medical Doctor (MD), the designated resident representative/Guardian for the resident, Coroner/Funeral Home and the nurse also notifies the Administrator and me the DON. She was asked, Was the guardian notified when this resident expired? She stated, Yes she was notified. I talked to the nurse and she told me she left a message, but no one ever called her back. On the day of his passing she was called, and a message was left at 02:45AM. d. On [DATE] at 02:49 PM, the Administrator, was asked, If a resident is a ward of the state, who do you notify when he/she expires? She stated, We notify the APS resident representative/Guardian first then the doctor, Funeral Home and the nurse will notify me, the Administrator and the DON. She was asked, Was the guardian notified when this resident expired? She stated, The nurse called and left a message on the answering machine. She was asked, Did anyone follow up the next day with the resident representative, due to the resident expired after hours? She stated, No we don't usually call the family or the guardian back, they will usually call us back when they get the message. She was asked, Do you have a protocol for notifying the POA/Guardian when a resident expires? She stated, We leave a message, but we don't have a set protocol. e. On [DATE] at 03:26 PM, Licensed Practical Nurse (LPN) #1 was asked, Who did you notify the night this resident passed away? She stated, I notified the MD, the coroner, I left a message on the state on-call phone, the Administrator and the DON. She was asked, Did you talk to the Guardian that is listed on the resident's face sheet? She stated, No I didn't talk to her because no one answers the on-call number, so I left a message. She was asked, Did you follow up the next day in an attempt to notify the Guardian listed on the face sheet for (Resident #1)? She stated, Yes, I did try and call all three numbers that are listed, and I left a message, but I didn't document my calls and I know that's all on me. f. As of [DATE] at 10:00 a.m., there was no documentation in the resident's electronic record to indicate the designated resident representative was notified by the facility.</p>		
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE		TITLE	(X6) DATE

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.