

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENTIFICATION NUMBER <b>045394</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED <b>09/18/2020</b>
NAME OF PROVIDER OF SUPPLIER <b>RECTOR NURSING AND REHAB</b>		STREET ADDRESS, CITY, STATE, ZIP <b>1023 HIGHWAY 119 RECTOR, AR 72461</b>	
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 0641  <b>Level of harm</b> - Minimal harm or potential for actual harm  <b>Residents Affected</b> - Few	<b>Ensure each resident receives an accurate assessment.</b> **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure the Minimum Data Set (MDS) assessment was properly coded to reflect the presence of a Serious Mental Disorder for 2 (Residents #9 and #20) of 2 sampled residents who required Level II evaluations per the Medicaid Preadmission Screening and Resident Review (PASRR) process. The failed practice had the potential to affect 4 residents who required PASRR II evaluations according to a list provided by the Administrator on 09/17/2020 at 1:50 PM. The findings are: 1. Resident #20 was admitted [DATE] and had [DIAGNOSES REDACTED]. The Annual MDS with an Assessment Reference Date (ARD) of 07/01/2020 documented, .Is the resident currently considered by the state level II PASRR process to have serious mental illness .the item was coded 0 (no). Also documented the resident had a Psychiatric/Mood disorder. a. A physician's orders [REDACTED].[MEDICATION NAME] .related to [MEDICAL CONDITION] II Disorder; [MEDICAL CONDITION] . b. The Comprehensive Care Plan dated 07/23/2020 documented, .The resident uses [MEDICAL CONDITION] medications antipsychotic, antianxiety and antidepressant r/t (related to) Disease process of [MEDICAL CONDITIONS] and depression . c. On 09/16/2020 at 2:01 PM, the MDS Coordinator was asked, Should you have coded item A1500 on the Annual MDS as no? She stated, Yes, that's the way I've always done it. She was asked, Is the resident considered to have serious mental illness per the level II screening? She stated, .He was a level II, but he went down to a level I . She was asked, Did you mark the MDS indicating the resident has [MEDICAL CONDITION] Disorder and [MEDICAL CONDITION]? She stated, Yes . I marked it the way I was trained to mark it. d. On 09/16/2020 at 2:25 PM, a form titled CMS's RAI (Centers for Medicare and Medicaid Resident Assessment Instrument) Version 3.0 Manual .provided by the MDS Coordinator documented, .Page A-23 .A1500: Preadmission Screening and Resident Review (PASRR) .Code 1, yes: if PASRR Level II screening determined that the resident has a serious mental illness .and continue to A1510, Level II Preadmission Screening and Resident Review (PASRR) Conditions. e. On 09/17/2020 at 11:12 AM, a (Mental Health) Associates letter provided by the Administrator documented, .Recently an evaluation was completed of your physical and mental condition in compliance with Federal Law regarding nursing facility admission .As a result of your evaluation it has been determined that: You Do require specialized services for your mental illness (MI) . f. On 09/17/2020 at 10:24 AM, the Administrator and Nurse Consultant were asked, Should item A1500 on the Annual MDS dated [DATE] be coded yes? They both stated, Yes. 2. Resident #9 had [DIAGNOSES REDACTED]. The Significant Change MDS with ARD of 05/15/2020 documented, .Is the resident currently considered by the state level II PASRR process to have serious mental illness .the item was coded 0, (no) . Resident had an active [DIAGNOSES REDACTED].boxes beside [MEDICAL CONDITION] and [MEDICAL CONDITION] were marked. a. A physician's orders [REDACTED].[MEDICATION NAME] . related to Paranoid [MEDICAL CONDITION] . b. The Comprehensive Care Plan dated 08/25/2020 documented, .The resident exhibits behavioral indicators of sexual inappropriate behaviors, threatening staff .r/t (related to) Dx (Diagnosis) of .unspecified [MEDICAL CONDITION] and paranoid [MEDICAL CONDITION] . c. On 09/17/2020 at 10:55 AM, a (Mental Health) Associates letter dated 8/18/2016 provided by the Administrator documented, .Client has mental illness with severe dementia .box beside this statement was marked with an X. d. On 09/17/2020 at 10:24 AM, the Administrator and Nurse Consultant were asked, Should item A1500 on the Annual MDS dated [DATE] be coded yes? They both stated, Yes.		
F 0695  <b>Level of harm</b> - Minimal harm or potential for actual harm  <b>Residents Affected</b> - Few	<b>Provide safe and appropriate respiratory care for a resident when needed.</b> **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interview, the facility failed to ensure appropriate infection prevention and control practices were implemented during oxygen administration to prevent potential contamination for 1 (Resident #20) of 1 sampled resident who was receiving oxygen therapy. The failed practice had the potential to affect 14 residents who had physician's orders [REDACTED]. The findings are: Resident #20 had [DIAGNOSES REDACTED]. a. The physician's orders [REDACTED].@ (at) 2L (Liters) via NC (Nasal Cannula) as needed . b. The September 2020 Comprehensive Care Plan documented, .The resident has altered respiratory status/difficulty breathing r/t (related to) [MEDICAL CONDITION] .Interventions: OXYGEN SETTINGS: O2 via (nasal prongs) @ (2-3) L . c. On 09/14/2020 at 12:39 PM, Resident #20 was sitting in a chair in his room without O2 on. The nasal prongs of the O2 tubing was in the floor. The switch on the concentrator was in the on position. Certified Nursing Assistant (CNA) #1 was informed that Resident #20's tubing was on the floor. She stated, .he takes it off all the time. d. On 09/14/2020 at 12:52 PM, the Director of Nursing (DON) entered the room and picked oxygen tubing up from the floor and applied the nasal cannula to the resident. She did not change the tubing. e. On 09/14/2020 at 03:11 PM, the DON was asked, When you picked the oxygen tubing off the floor for Resident #20 what did you do with it? She stated, I know, I should have got a new one.		
F 0881  <b>Level of harm</b> - Minimal harm or potential for actual harm  <b>Residents Affected</b> - Some	<b>Implement a program that monitors antibiotic use.</b> **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure protocol was followed for a telephone ordered antibiotic for 1 (Resident #18) of 8 (Resident #18, #14, #7, #10, #33, #4, #13 and #37) sampled residents who had orders for antibiotic therapy. This failed practice had the potential to affect 14 residents under this physicians' care, according to the list provided by the Assistant Director of Nursing (ADON) on 9/17/20. The findings are: 1. A telephone order dated 7/16/20 documented, (Resident #18) . Ordered by: (Medical Doctor #1) . Medication:[MEDICATION NAME] 500MG (milligram) . Order Type: Antibiotic Orders . a. The July 2020 Medication Administration Record [REDACTED]. b. The Antibiotic and Infection Monitoring Log for July 2020 was received from the ADON on 9/17/20 at 3:25 p.m. The log documented on 7/12/20, Resident #18 was [MEDICATION NAME] mg (milligram) for an UTI from Medical Doctor #1. c. On 9/17/20 at 8:28 a.m., the ADON was asked, When does (MD #1) see his residents? She stated, He only comes once a month to see his residents. She was asked, Does anyone else see his residents. She stated No. She was asked, If he prescribed an antibiotic over the phone, when does he see / assess the resident? She stated, When he makes his monthly visit. d. On 9/17/20 at 2:41 p.m., a copy of the Antibiotic Stewardship was received from the ADON and documented, Antibiotics will be prescribed and administered to residents under the guidance of the facility's Antibiotic Stewardship Program .The purpose of our Antibiotic Stewardship Program is to monitor the use of antibiotics in our residents . When antibiotics are prescribed over the phone, the primary care practitioner will assess the resident within 72 hours of the telephone order . e. On 9/18/20 a copy of the Physician's Visits was received from the ADON and documented that MD #1 visited Resident #18 on 6/19/20 and 8/28/20.		
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.