STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045352	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/06/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Eaglecrest Nursing and Rehab	916 Highway 62/412 Ash Flat, AR 72513

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 0583 Level of Harm - Potential for minimal harm Residents Affected - Some	Keep residents' personal and medical records private and confidential. 46032 Based on observation, interview, and record review, the facility failed to ensure medical information on a computer screen was not visible to other staff, residents and/or visitors to prevent private medical information from being improperly divulged as evidenced by computer screens left open with resident information visible for 2 (Residents #125 and #170) of 2 sampled residents. This failed practice had the potential to affect 74 residents per the Resident Census provided by the Administrator on 10/3/22. The findings are: 1. On 10/04/22 at 2:23 PM, the Surveyor entered the therapy room at the end of the 400 Hall. A computer tablet was sitting on a desk with Resident #170's information still up on the screen with no staff present. The Surveyor waited until 2:29 PM to see if a therapist was going to return to the room. As the Surveyor stepped out of the therapy room, Resident #65's family member was outside door. The Surveyor informed the family member that there was not a therapist in the room right now and the family member continued down the hall to Resident #65's room. a. On 10/04/22 at 2:32 PM, the Surveyor informed the Administrator of the computer screen being left up in the therapy room with Resident #170's information visible. The Surveyor asked the Administrator, Should computers be left up when staff leaves their desk and the room their computer is in? The Administrator stated, No, never, but even if they do, ours rolls to the privacy screen in a few seconds. The Surveyor asked, Are all the computers in the facility set up that way? The Administrator stated, All the kiosks and touch books do. The Surveyor asked, Does therapy use that system? The Administrator stated, Oh no, they are on a different system. The Surveyor informed Administrator about laptop computer in the therapy room being left up with a resident's information showing. The Administrator stated she was not sure what therapists were still in the building but would see. 2. On 10/4/22 at 2:40 PM, the Surveyor asked Occupational Therapist (OT) #1 as she was exiting Resident #15's room on the 200 Hall, When you leave your desk or therapy room should computers be left open? OT #1 responded, No, and you should not leave a screen up with resident info [information] on it. Physical Therapist (PT) #1 walked up to the Surveyor and OT #1 and the Surveyor informed them that a computer in the therapy room was left up with resident information on it. 3. On 10/4/22 at 2:45 PM, PT #1 and the Administrator came to Surveyor and PT #1 stated therapy had just received new computer software yesterday (Monday) and it does not go to the privacy screen automatically like the last system did. PT #1 stated they were not use to not the new system not doing that. The Administrator confirmed this statement. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045352	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/06/2022
NAME OF PROVIDER OR SUPPLIER Eaglecrest Nursing and Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE 916 Highway 62/412 Ash Flat, AR 72513	

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F 0583 Level of Harm - Potential for minimal harm Residents Affected - Some	4. On 10/4/22 at 3:50 PM, the Surveyor was on the 400 Hall and noticed a computer in the Nurses Station was on with Resident #125's information on the screen and no staff nearby. 5. On 10/4/22 at approximately 3:55 PM, the Surveyor informed the Administrator of another computer screen left up. The Surveyor accompanied the Administrator to the 400 Hall Nurses Station. The computer screen was still open with the resident's information visible. The Administrator stated, She only walked away a minute ago because I heard her voice. The Surveyor asked if the computer screen should have been left up. The Administrator stated, She should be close by. I just heard her. The Administrator closed the screen and logged the computer out.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 36821 Based on record review and interview, the facility failed to ensure a comprehensive plan of care was developed for a resident who had a Foley Catheter to assure the resident's individual needs were met and maintained for 1 (Resident #37) of 3 (Residents #27, #33 and #37) sampled residents who had a catheter. The findings are: 1. Resident #37 had diagnoses of Urinary Retention and Unspecified Dementia without Behavioral Disturbances. The Significant Change Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 8/23/22 documented the resident scored 6 (0-7 indicates severely cognitively impaired) on a Brief Interview for Mental Status (BIMS) and had a Foley catheter. a. The Physician's Order dated 07/01/22 documented, .Foley french [catheter] (_16_) and bulb (_10_) cc [cubic centimeters] . b. The Care Plan with a revision date of 07/14/22 documented, . has an ADL [activities of daily living] self-care performance deficit . TOILET USE: The resident requires extensive assistance by 1 staff for toileting . The Care Plan did not address that the resident had a Foley catheter or interventions and/or task to care for the foley catheter. c. On 10/03/22 at 10:58 AM, Resident #37 was lying in bed. Her Foley catheter bag was lying on the floor. d. On 10/04/22 at 8:31 AM, Resident #37's family member was sitting beside the bed and holding Resident #37's hand. The Foley catheter was secured to the left side of the bed, touching the floor. e. On 10/04/22 at 11:20 AM, the Surveyor requested Certified Nursing Assistant (CNA) #2 to follow the surveyor into Resident #37's room. Resident #37 was sitting up in bed with her family member sitting next to her holding her hand. The Surveyor asked CNA#2, Where is her catheter bag? She stated, .It is touching the floor. It is hard to find a place to hook. I didn't know where else to put it . because the bed is so low . f. On 10/06/22 at 10:18 AM, the Surveyor asked the MDS Coordinator, Does [Resident #37] have a Foley Catheter? She stated, Yes . The Surveyor asked, What care plan interventions do you have in place for the Foley catheter? She looked at her computer screen and stated, I can't find anything in there about the catheter . The Surveyor asked, What is a potential negative outcome of Foley catheter interventions not being on the care plan? She stated, If there are orders in place then it's being taken care of. The Surveyor requested a Care Plan policy. k. At the time of exit on 10/6/22 at 1:08 PM, a Care Plan policy had not been provided.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. 37145 Based on observation, record review, and interview, the facility failed to ensure indwelling catheter drainage bags were not touching the floor to prevent the potential complications and possible infections for 2 (Residents #33 and #37) of 3 (Residents #27, #33 and #37) sampled residents who had indwelling catheters. This failed practice had the potential to affect three residents who had catheters according to a list provided by the Administrator on 10/05/22 at 8:47 AM. The findings are: 1. Resident #33 had diagnoses of Neuromuscular Dysfunction of Bladder and Retention of Urine. The Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 08/18/22 documented the resident was severely impaired in cognitive skills for daily decision making per a Staff Assessment for Mental Status (SAMS) and had an indwelling catheter. a. The Physician's Order dated 08/19/20 documented, . Foley french (20) and bulb (30) cc [cubic centimeter]: change foley cath [catheter] Q [every] 60 days PRN [as needed] FOR REASON OF leakage obstruction or dislodgement . b. The Care Plan with a revision date of 05/26/21 documented, . has Suprapubic Catheter . Position catheter bag and tubing below the level of the bladder and away from entrance room door . Check tubing for kinks each shift . c. On 10/03/22 at 11:13 AM, Resident #33 was lying in bed, her foley catheter drainage bag was hanging on the right side of the bed touching the floor. A privacy bag was hanging beside the drainage bag, but the drainage bag was not in it. d. On 10/04/22 at 8:39 AM, Resident #33 was lying in bed, her foley catheter drainage bag was hanging on the right side of the bed touching the floor. A privacy bag was hanging beside the drainage bag. e. On 10/05/22 at 9:15 AM, Resident #33 was lying in bed, her foley catheter drainage bag was hanging from the right side of bed in a privacy sleeve with no bottom and was touching the floor. The Director of Nursing (DON) was called into the resident's room and made aware of the finding of the last two days. The Surveyor asked if it was appropriate for it to be touching the floor now. The DON stated, It should be hanging from the end of the bed, so it doesn't touch the floor. 36821 2. Resident #37 had diagnoses of Urinary Retention and Unspecified Dementia without Behavioral Disturbances. The Significant Change Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 8/23/22 documented the resident scored 6 (0-7 indicates severely cognitively impaired) on a Brief Interview for Mental Status (BIMS) and had a a Foley catheter. a. The Physician's Order dated 07/01/22 documented, . Foley french [catheter] (_16_) and bulb (_10_) cc [cubic centimeters] . (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	b. The Care Plan with a revision date of 07/14/22 did not address that the resident had a Foley catheter or interventions and/or task to care for the foley catheter. c. On 10/03/22 at 10:58 AM, Resident #37 was lying in bed. Her Foley catheter bag was lying on the floor. d. On 10/04/22 at 8:31 AM, Resident #37's family member was sitting beside the bed and holding Resident #37's hand. The Foley catheter was secured to the left side of bed, touching the floor. e. On 10/04/22 at 11:20 AM, the Surveyor requested Certified Nursing Assistant (CNA) #2 to follow the Surveyor into Resident #37's room. Resident #37 was sitting up in bed with her family member sitting next to her holding her hand. The Surveyor asked CNA#2, Where is her catheter bag? She stated, .It is touching the floor. It is hard to find a place to hook. I didn't know where else to put it . because the bed is so low . f. On 10/04/22 at 11:24 AM, the Surveyor asked CNA #2, What is a potential negative outcome of her urinary catheter sitting on the floor? She stated, Germs could get in it . We raise the bed up and her husband lowers it so he can put his arm around her, and he leans on her bed . g. On 10/04/22 at 1:16 PM, the Surveyor asked the Administrator for a policy regarding catheters. The Administrator stated, Is this regarding [Resident #37]? If it is, she is a little demented and he [family member] has been educated in not lowering the bed so her catheter is not on the floor. I can't help what resident's and their families do when we are not in there . 3. The facility policy titled, Catheter Care, Urinary, provided by the Administrator on 10/04/22 at 1:18 PM documented, .The purpose of this procedure is to prevent catheter-associated urinary tract infections . Infection Control . b. Be sure the catheter tubing and drainage bag are kept off the floor .

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. 36821 Based on observation, record review, and interview, the facility failed to ensure an oxygen tank was not stored in a resident's room to prevent the potential for injury for 1 (Resident #56) of 6 (Residents #15, #32, #37, #55, #56 and #65) sampled residents who received oxygen therapy. The findings are: 1. Resident #56 had diagnoses of Chronic Obstructive Pulmonary Disease with Acute Exacerbation, Muscle Weakness and Congestive Heart Failure. The Admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 9/10/22 documented the resident scored 15 (13-15 indicates cognitively intact) on a BIMS (Brief Interview for Mental Status) and receive oxygen therapy and Non-Invasive Mechanical Ventilator (BiPAP [Bilevel Positive Airway Pressure]/CPAP [Continuous positive airway pressure]). a. The Physician Orders dated 09/07/22 documented, .BIPAP 5cm [cubic centimeters] H2O [water] at bedtime and prn [as needed] daytime naps . OXYGEN- may self-remove if desired as needed for SHORTNESS OF BREATH 3 LITERS/[per] MIN PER NASAL CANNULA PRN . b. On 10/03/22 at 11:19 AM, Resident #56 was sitting up in her room with oxygen in use per concentrator. A large oxygen tank was laying on resident's spare bed in her room, not in use. c. On 10/03/22 at 11:26 AM, Resident #56 was sitting in her room with oxygen at 5 liter per mask. An oxygen tank was laying on the bed not in use. d. On 10/03/22 at 12:06 PM, the Surveyor requested the Nurse Manager to come to Resident #56's room. A large oxygen tank was lying on the empty bed in the resident's room. The Surveyor asked the Nurse Manager, Who is responsible for ensuring the oxygen tanks are stored safely? She stated, Nursing. The Surveyor asked her to describe where the oxygen tank was and she stated, It's lying on the bed. The Surveyor asked, Is it stored safely? She stated, No. The Surveyor asked, What is a potential negative outcome of the oxygen laying on the bed and not stored safety? She stated, It could roll off the bed and be a tripping hazard and . on an extreme outcome it could explode. The Nurse Manager removed the tank from the room. 2. The facility policy titled, Oxygen Safety, provided by the Administrator on 10/4/22 at 1:18 PM documented, Oxygen Safety: .Store oxygen cylinders in racks with chains, sturdy portable carts .Never leave oxygen cylinders free-standing. Do not store oxygen cylinders in any resident room .