

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENTIFICATION NUMBER 045289	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/24/2020
NAME OF PROVIDER OF SUPPLIER LONOKE HEALTH AND REHAB CENTER, LLC		STREET ADDRESS, CITY, STATE, ZIP 1501 LINCOLN STREET LONOKE, AR 72086	
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 0883 Level of harm - Minimal harm or potential for actual harm Residents Affected - Few	<p>Develop and implement policies and procedures for flu and pneumonia vaccinations.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</p> <p>Based on record review and interview, the facility failed to ensure the Pneumococcal Vaccine was administered upon acceptance / consent of the Pneumococcal vaccine for 1 (Resident #5) of 1 sampled residents who did not receive the Pneumococcal vaccine after consent was received. This failed practice had the potential to affect 30 residents who were admitted since February 2020, according to the list provided by the Director of Nursing (DON) on 9/25/2020. The findings are: Resident #5 was admitted on [DATE] from Acute Care with [DIAGNOSES REDACTED]. The Quarterly Minimum Data Set with an Assessment Reference Date of 9/1/2020 documented the resident scored 14 (13-15 indicates cognitively intact) on a Brief Interview for Mental Status and Pneumococcal Vaccine not up to date, not eligible. a. A form titled Consent for Pneumococcal Vaccine was dated as signed on 2/20/2020. b. On 9/25/2020 at 12:35 p.m., the Director of Nursing (DON) was asked if (Resident #5) had received his Pneumococcal Vaccine. She stated, I'll have to check on that. c. On 9/25/2020 at 12:56 p.m., the DON called and stated, We just didn't give it. I try so hard to stay on top of everything, but this one I just missed. He had a consent signed 'yes' for it. I called the ANP (Advanced Nurse Practitioner) and we will give it today.</p>		
F 0885 Level of harm - Potential for minimal harm Residents Affected - Many	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</p> <p>Based on record review and interview, the facility failed to ensure residents and the resident representatives and / or families were notified of a confirmed case of COVID-19 by 5:00 p.m. the next calendar day after a confirmed case of COVID-19 of a resident was identified for 4 (Residents #1, #2, #4, and #5) of 5 (Residents #1, #2, #3, #4, and #5) sampled residents. This failed practice had the potential to affect 52 residents who resided in the facility, according to the Census List provided by the Administrator on 9/24/2020. The findings are: 1. Resident #1 had a [DIAGNOSES REDACTED]. a. A laboratory test result dated 9/3/2020 documented COVID-10 testing was completed on 9/3/2020, and a laboratory report dated 9/4/2020 indicated positive results were received. b. The Care Plan dated 9/3/2020 documented the resident had a positive COVID-19 test. c. A Social / Activities Note dated 9/5/2020 at 1532 (3:32 p.m.) documented, .Informed family that a staff person tested positive for COVID-19 . There was no documentation to indicate the family was notified of the resident's Positive COVID-19 results. 2. Resident #2 had a [DIAGNOSES REDACTED]. a. A laboratory test dated as collected on 9/3/2020 documented positive results reported on 9/4/2020. b. A Nurse's Note dated 9/15/2020 documented, .admitted to (Hospital) with COVID-19 Pneumonia . The Nurse's Notes contained no documentation related to notification of resident family or representative of COVID-19 testing or results. 3. Resident #4 had a [DIAGNOSES REDACTED]. The Quarterly MDS with an ARD of 7/15/2020 documented the resident scored 10 (8-12 indicates moderate impairment) on a BIMS. a. A Social / Activity Note dated 8/19/2020 at 11:06 a.m. documented, .Informed family that a COVID-19 testing will be done today . As of 9/25/2020 at 9:10 a.m., there was no documentation to indicate the family was notified of the results of the testing. 4. Resident #5 was admitted on [DATE] from Acute Care with [DIAGNOSES REDACTED]. The Quarterly Minimum Data Set with an Assessment Reference Date of 9/1/2020 documented the resident scored 14 (13-15 indicates cognitively intact) on a Brief Interview for Mental Status. a. A laboratory test dated as collected on 9/15/2020 was in the resident's medical record. A laboratory result dated 9/16/2020 documented negative results for the COVID-19 test. b. As of 9/25/2020 at 9:15 a.m., the medical record contained no documentation regarding COVID-19 testing notification of the resident / family. 5. On 9/25/2020 at 11:49 a.m., the Director of Nursing (DON) was asked, Who is responsible for resident / family notification of COVID testing and for results? She stated, It's kind of split up between Administrator, the nurses, Social / Activities. 6. On 9/25/2020 at 11:56 a.m., the Social / Activity Director was asked, When did you begin in this position? She stated, (Name) left last week. She was asked, When and where are you supposed to notify the resident and family that a test is going to be done and with the results? She stated, I've been doing it as a Progress Note as soon as I'm made aware. 7. On 9/25/2020 at 11:57 a.m., the Administrator was asked about notification and scanning documents into facility software? The Administrator stated, No one is responsible. That's why they're not all in . 8. A facility policy titled Guidelines for Suspected or Confirmed COVID-19 provided by the Administrator on 9/24/2020 documented, .The facility will provide communication for COVID-19 (initial, ongoing, and upon suspected of confirmed outbreak) through multiple means (i.e. (for example)) signage at entrance / exits, letters, phone calls) .</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.