STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045070	A. Building B. Wing	01/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rogers Health and Rehabilitation Center	1149 W New Hope Rd Rogers, AR 72758

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 47916 Based on observation, record review, interview, and facility policy review, the facility failed to ensure the rear casters on the mechanical lift remained unlocked during lifting a resident to allow for stabilization, and to prevent injuries or tipping affecting 1 (Resident #41) of 1 sampled resident reviewed for lift. The findings include: A review of Medical Diagnoses revealed Resident #41 had diagnoses of stroke, diabetes, and kidney disease. The significant change Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 06/16/2024 suggested a Staff Assessment for Mental Status (SAMS) indicated short- and long-term memory problems. Section H0400 indicated the resident was always incontinent of stool, and section H0100 indicated Resident #41 had a catheter. a. On 01/21/2025 at 02:12 PM, Resident #41 returned to the room to be transferred to the bed using a mechanical lift. Certified Nursing Assistant (CNA) #4 placed the open mechanical lift legs around Resident #41's chair with the rear casters in the locked position. The resident was raised using a purple lift pad and clips were in place. Once raised all the way up, the wheels were unlocked, and Resident #41 was rolled over to the bed. The legs of the lift remained in the open position, and Resident #41 was lowered down to the bed with the rear casters/wheels locked. This surveyor asked about the purpose of locking the rear casters. CNA #4 stated the rear wheels were locked for stability and to keep the mechanical lift from moving and possibly tipping. b. On 01/22/2025 at 02:22 PM, the Director of Nursing (DON) was asked the process for raising and lowering residents with a mechanical lift. The DON said they would lock the brakes when raising someone up and the legs should be in the open position. When asked why they would want the wheels to be locked when raising or lowering residents, the DON stated to keep the lift from moving or rocking because that could cause severe issues. The DON was asked for the mechanical lift user ' s manual to confirm lift procedure. c. On 01/22/2025 at 03:00 PM, the Administrator pulled up the mechanical lift user ' s manual on the computer. The manual revealed the rear casters should never be locked when raising and lowering residents for safety reasons. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 03508 Based on observation, interview, record review, and facility policy review, the facility failed to ensure the kitchen walls, tiles, air vents, and door frames were maintained in good repair and were free of chips, stains and rust; baseboards were secured and were maintained in clean sanitary conditions; and dietary staff washed their hands before handling clean equipment for 2 of 2 meals observed. The findings are: 1. On 1/21/25 at11:51 AM, the following observations were made in the kitchen areas: a. The florescent light above the steam table had no cover over it, electrical wires were exposed. b. The ceiling tiles around the emergency window by the steam table had brown stains on it. c. The kitchen floor by the steam table was chipped, in three (3) different areas exposing the concrete. d. The baseboard tile below the steam table was missing. e. The wall by the pipe connected to the switch attached to the plate warmer was cracked and the concrete was exposed. f. The wall leading to the Dietary Manager's office from the kitchen was cracked and the concrete was exposed. g. The bottom of the door leading to the Janitor's closet was chipped and the wood was exposed. h. The right-side door frame to the Janitor's closet was loose. i. The air vent close to the hand washing sink was loose. The ceiling tile above the hand wash sink had yellow stains and cracks on it. j. The door frame by the food preparation area and the door leading to the walk-in refrigerator was chipped, exposing the concrete. k. The ceiling tile above the ice machine was loose exposing the pipe. l. The air vent above the ice scoop holder by the ice machine had rust. m. The ceiling tile by the ice machine water had damage on it. n. One (1) of two (2) ceiling florescent lights between the two-door refrigerator and milk refrigerator had no light covering on it. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	o. The dishwashing machine floor tile was missing in 10 different areas and the concrete was exposed. Five tiles were loose in the dishwashing machine room. The areas where tiles were missing or loose had water standing in them exposing the concert. p. The bathroom floor leading to the heating room, storage room, and leading to the dining room had a buildup of black residue on them. The door frames were rusty. q. The bottom of the door frames leading to the storage room were rotted. r. The door frames leading to the outside from the kitchen were chipped and the metal was exposed. 2. On 1/21/25 at 12:24 PM, Dietary Aide (DA) #1was on the tray line assisting with the lunch meal. DA #1 picked up cartons of milk, cartons of health shakes, and cartons of ice cream and placed them on the meal trays, contaminating her hands. Without washing her hands, DA #1 picked up glasses with beverages by their rims and placed them on the trays to be served to the residents for lunch. DA #1 was interviewed and was asked what she should have done after touching dirty objects and before handling clean equipment. She stated she should have washed her hands. 3. On 1/21/25 at12:40 pm, Dietary Aide (DA) #2 turned on the hand washing sink and washed his hands. After washing his hands, DA #2 turned off the sink faucet, with his hands contaminating his hands in the process. Without washing his hands, DA #2 picked up individual napkins, placed utensils inside, and wrapped them for the residents to use during the noon meal, also picked glasses by their rims and placed them on the tray to be used in serving beverages to the residents for the meal. 4. On 1/21/25 at 12:50 PM, DA #1 pushed a cart with a pan containing a small amount of ice. In the pan were 2 leftover cups of vanilla ice cream, 6 leftover cups of chocolate ice cream and 12 leftover cups of strawberry ice cream. DA #1 pushed the cart toward the door leading to the walk-in freezer. As DA #1 opened the freezer door to place the leftover cups of ice cream in the freezer to refreeze, DA #1 was interviewed and was asked to describe how the ice cream cups looked. The Dietary Manager stated each ice cream cup was soft and she would throw them away. The Dietary Manager was interviewed and was asked how many cartons of ice cream were left in the pan. She counted them and stated there were 2 cups of vanilla ice cream, 6 cups of chocolate ice cream and 12 cups of strawberry ice cream. During an interview, the Dietary Manager was asked if cups of ice cream that has been on ice and have become soft could be refrozen. The Dietary Manager stated it shouldn't be refrozen, and she would throw them away. The manufacturer's instructions on the carton of ice cream documented, Keep Frozen. 5. On 1/21/25 at 3:33 PM. DA #2 turned on the hand washing sink and washed his hands. After washing his hands, DA #2 turned off the sink faucet, with his hands contaminating his hands in the process. Without washing his hands, DA #2 picked up individual napkins, placed utensils inside, and wrapped them for the residents to be used during the meal. DA #2 also picked glasses up by their rims and placed them on the tray to be used in serving beverages to the residents for the supper meal. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	6. On 1/21/25 at 3:58 PM, DA #2 turned off the sink faucet with his hands contaminating his hands in the process. Without washing his hands, DA #2 picked up coffee cups by their rims and placed them on counter to be used in serving beverages to the residents for supper meal. DA #2 was interviewed and asked what he should have done after touching dirty objects and before handling clean equipment. DA #2 confirmed turning off the sink faucet with his bare hands made them dirty and he should have washed his hands again. 7. A review of facility policy titled, Handwashing and Glove Usage in Food service, initiated 2016, provided by the Dietary Manager on 1/22/2025 indicated, food handlers should wash their hands before starting work, after touching dirty dishes or clothing and after touching anything else such as dirty equipment.