STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045157	A. Building B. Wing	05/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
River Ridge Rehabilitation and Care Center	1100 East Martin Drive Wynne, AR 72396

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. 48630 Based on observations, interviews, record review, facility document review, and facility policy review, it was determined the facility failed to perform proper incontinent care for 1 (Resident #9) of 1 resident reviewed for incontinent care. Findings include: A review of the Order Summary Report, indicated the facility admitted Resident #9 with diagnoses that included morbid (severe) obesity due to excess calories, dysuria, urinary tract Infection. The Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 04/08/2024 revealed Resident #9 had a Brief Interview for Mental Status (BIMS) score of 14 which indicated the resident was cognitively intact. The MDS indicated the resident was substantial/maximal assistance with toileting hygiene. A review of Resident #9's Care Plan, revised 04/19/2024, revealed the resident is at risk for impaired skin integrity r/t (related to) incontinence, impaired mobility, obesity, circulatory issues associated with atherosclerotic heart disease, scoliosis, and DM (diabetes mellitus). Interventions included provide incontinent/peri-care after each incontinent episode and as needed dated 07/09/2019. During an observation on 05/31/2024 at 11:32 AM, Certified Nursing Assistant (CNA) #12 assisted CNA #7 in rolling the resident to a left side lying position. CNA #12 used disposable wipes to clean an incontinent episode from the base of the buttocks near the anus and cleansed upwards. After pausing to ensure all stool was removed CNA #12 noted solid waste below the resident's buttocks, cleansed the area with disposable wipes, and applied barrier cream to the sacrum. A clean brief was placed behind the resident, the resident was rolled onto their back and CNA #12 and #7 secured the brief, repositioned resident, and exited the room. Licensed Practical Nurse (LPN) #10 was present in the room but never advised the CNAs otherwise. Resident #9 was noted to have been incontinent of solid waste, and neither the CNAs or the LPN cleaned the perineal area. During an interview on 05/31/2024 at 01:56 PM, CNA #12 confirmed only the backside was cleaned during the incontinence episode task and the front should have been cleaned as well. CNA #12 said to the Surveyor that by not cleaning the perineal area there was a potential to cause yeast infections or urinary tract infections. (continued on next page)

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

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	045157	A. Building B. Wing	05/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 05/31/2024 at 02:30 PM, LPN #10 confirmed incontinent care was only performed from the anus to the rear, and that the front should have been cleaned as well. LPN #10 added that by not cleaning the perineal area the resident was at risk for skin breakdown and urinary tract infections. During an interview on 05/31/2024 at 02:40 PM, the Director of Nursing (DON) stated that incontinent care with stool involved should include cleaning from the top of the buttocks to the thighs, between the thighs, and the front. The DON added this is to ensure that the resident does not endure any skin breakdown or a urinary tract infection from stool entering the urinary tract. A review of a facility policy titled, Perineal Care, dated 2017, indicated, .Using gentle downward strokes, clean from the front to the back of the perineum to prevent intestinal organisms from contaminating [perineal area]. Turn the patient on his/her side to the [left side, left hip and lower extremity straight, and right hip and knee bent] position, if possible, to expose the anal area. Clean, rinse, and dry the anal area, .wiping from front to back. After cleaning the perineum, apply a moisture-barrier skin protectant as needed.

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	045157	A. Building B. Wing	05/31/2024

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. 50682 Based on observation, interviews, and record review, the facility failed to ensure assistance in positioning/repositioning were provided for 1 (Resident #26) of 1 sampled resident who required assistance. Findings include: 1. A review of the Order Summary indicated Resident # 26 had diagnoses of cerebral infarction, retention of urine, and obstructive and reflux uropathy. a. The Admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 03/15/2024 indicated a Brief Interview for Mental Status (BIMS) score of 9 (8-12 indicated moderately impaired). b. The Care Plan dated 03/24/2024 included, Bed Mobility: Substantial/maximal assistance - Helper does MORE THAN HALF the effort. The helper lifts or holds trunk or limbs and provides more than half the effort. c. On 05/29/2024 at 12:49 PM, a lunch tray was provided for Resident #26. Resident #26 was lying with the head of the bed elevated and was not positioned high enough in the bed to be able to reach the meal tray. The meal tray was on the bedside table to the left side of the resident's bed, not across the bed. Resident #26 was observed trying to eat and struggling to reach the tray. d. On 05/29/2024 at 1:00 PM, Certified Nursing Assistant (CNA) # 8 was asked if the resident was positioned correctly to feed themselves. CNA #8 said Resident #26 should be positioned higher in the bed and the bedside table should be across the bed and not on the side of the bed. e. On 05/29/2024 at 1:00 PM, CNA #11 was asked if Resident #26 was positioned correctly in bed in order to feed themself. CNA #11 said Resident #26 should be positioned higher in the bed and the bedside table should be across the bed and not on the side of the bed. f. On 05/31/2024 at 8:47AM, Licensed Practical Nurse (LPN) #10 was asked how a resident who required assistance in positioning should be positioned in the bed to feed themselves, and where should the meal tray be placed. LPN #10 said the resident should be positioned up in bed with the head of the bed elevated and the bedside table with the lunch tray on it should be across the bed. g. On 05/31/2024 at 8:47AM, the Director of Nursing (DON) was asked how a resident who required assistance in positioning should be positioned in the bed to feed themselves, and where should the meal tray be placed. The DON said the resident should be positioned up in bed with the head of the bed elevated and the bedside table with the lunch tray across the bed. h. On 05/31/2024 at 9:12 AM, the Administrator stated that the facility had no policy on positioning residents in bed.

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	045157	A. Building B. Wing	05/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. 50682 Based on observations, interviews, and record review, the facility failed to ensure a leg strap was in place to prevent trauma from the indwelling catheter for 1 (Resident #26) of 2 (Resident #26 and #54) sampled residents who were dependent on staff for indwelling catheter care. The findings are: 1. Resident #26 had diagnoses of retention of urine and reflux uropathy. a. An Admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 03/15/2024 indicated a Brief Interview for Mental Status (BIMS) score of 9 (8-12 indicated moderately impaired) and Resident #26 was admitted with an indwelling catheter. b. A review of the Physician Orders (dated, 05/23/24) revealed Resident #26 had an indwelling catheter, which was inserted through the urethra and left in the bladder to drain urine. c. A review of Resident #26's Care Plan with a revision date of 04/18/2024 revealed .The resident has foley catheter related to DX [diagnosis] of obstructive uropathy .position catheter bag and tubing below the level of the bladder, secure catheter tubing to leg with applicable device. d. On 05/29/2024 at 12:48 PM, Resident #26 was being repositioned in the bed by Certified Nursing Assistant (CNA) #8 and #11. The indwelling catheter was not secured to Resident #26's leg with a leg strap. e. On 05/29/2024 at 12:50 PM, CNA #8 was asked if the resident had anything to secure the tubing to the resident's leg to prevent pulling or tugging. CNA #8 said there was nothing to secure it. f. On 05/29/2024 at 12:51 PM, CNA #11 was asked if there should be something in place to prevent the catheter tubing from pulling or tugging and she said it should have something, but it does not. g. On 05/29/2024 at 08:45 AM, Licensed Practical Nurse (LPN) #10 was interviewed and asked if a resident who has an indwelling catheter should have a supportive device to keep it from pulling or tugging. LPN #10 said there should always be a leg strap or some type of secure device in place. LPN #10 was asked who would be responsible for ensuring it was in place and she said everyone should. h. On 05/29/2024 at 8:47 AM, the Director of Nursing (DON) was asked to explain the process for staff to follow to make sure the catheter tubing is stable or secured. The DON said the catheter tubing should be held in place by placing a leg band or something to secure the tubing on the resident. The DON was asked who should be responsible for ensuring the leg strap was in place and the DON said everyone should. i. On 05/29/2024 at 9:12 AM, the Administrator said the facility had no policy on indwelling catheter care.

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	045157	A. Building B. Wing	05/31/2024

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 49413 Through observation, record review, and interview, the facility failed to ensure expired medications were removed and placed into an area for destruction to prevent potential administration to residents. The findings are: 1. On 05/30/2024 at 1:40 PM, the following medicines or equipment were found expired in an area of the medication storage room used to store medications and supplies in active use: a. One hypodermic needle, 22-gauge x 1, expired on 03/31/2022. b. One 16 fluid ounce liquid multivitamin/mineral supplement expired 04/2024. c. 30 syringes - 1 milligram (mg) per 0.5 mL (milliliter) Lorazepam (Ativan) Intensol (benzodiazepines), expired on 05/04/2024. 2. On 05/30/2024 at 1:53 PM, Licensed Practical Nurse (LPN) #9 confirmed the expiration dates and stated neither the hypodermic needle nor the liquid multivitamin/mineral supplement should have been on the shelves. LPN #9 placed the items in the medication discard box. 3. On 05/30/2024 at 1:57 PM, LPN #10 confirmed the expiration date and the number of expired unused benzodiazepine oral syringes. LPN #9 and LPN #10 gave the benzodiazepine oral syringes to the Director of Nursing (DON). The DON confirmed the oral syringes were expired as of 05/02/2024.

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	045157	A. Building B. Wing	05/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
River Ridge Rehabilitation and Care Center	1100 East Martin Drive Wynne, AR 72396

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. 03508 Based on observation, record review, and interview, the facility failed to ensure meals were prepared and served according to the planned written menu, and recipes were followed to meet the nutritional needs of the residents for 2 of 2 meals observed. This failed practice had the potential to affect 15 residents who received mechanical soft diets and 21 residents who received enhanced diets from 1 of 1 kitchen. The findings are: 1. The menu for lunch documented the residents on mechanical soft diets were to receive 4 ounces of meat loaf and residents on pureed diets were to receive 2 ounces of gravy with mashed potatoes. a. On 05/28/2024 at 12:01 PM, Dietary Cook (DC) #1 placed 6 servings of meatloaf into a blender, ground and poured into a pan. DC #1 added 2 more servings of meat loaf, ground and poured in the same pan for a total of 8 servings, instead of 15 servings required per list the provided by the Social Director on 05/29/2024 at 08:56 AM. b. On 05/29/2024 at 11:01 AM, the Surveyor asked DC #1 how many mechanical soft diets there were in the facility. DC#1 stated, 15. Only 8 servings were prepared. The Surveyor asked if they should be short on their portions. DC #1 stated, No. We should not have any left over. The Surveyor asked DC #1, If the scoop was filled up, should you have any left over? DC #1 stated, No. c. On 05/28/2024 at 12:35 PM, a resident on puree diet was not served gravy with her noon meal. The menu indicated for the resident on puree was to receive 2 ounces of gravy with mashed potatoes. d. On 05/29/2024 at 11:01 PM, the Surveyor asked DC #1 the reason the resident on a puree diet did not receive gravy on the mashed potatoes. DC #1 stated, I did not see that. 2. The menu for breakfast revealed the residents on super calorie diets were to receive one cup of super cereal. a. On 05/29/2024 at 08:10 AM, all residents on super calorie diets were served a single portion of super cereal, instead of one cup as specified on the menu. b. On 05/29/2024 at 11:17 AM, the Surveyor asked DC #4 what scoop size she used to serve super cereal oatmeal. DC#4 stated, The (gray scoop #8) 1/2 cup to serve one serving each. 3. The Surveyor asked DC #1 how much water was used when pureeing meatloaf, lima beans, and bread. DC #1 stated she used one cup each. Cook #1 was asked what the best liquid to utilize to maintain nutrient use when pureeing food items. Cook #1 stated, Milk and broth off the meat. Cook #1 was asked how the food tastes when you use water. Cook #1 stated, It would not taste as good as it should be.

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	045157	A. Building B. Wing	05/31/2024

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 03508 Based on observation, record review, and interview, the facility failed to ensure the meals were served in a method that conserved nutritive value and maintained appearance, that cold product was stored at 41 degrees Fahrenheit or below, and hot food items were served at temperatures that were acceptable to the residents to improve palatability and encourage good nutritional intake during 1 of 1 meal observed. This failed practice had the potential to affect 9 residents who receive meal trays in their rooms on the A-Hall, 7 residents who receive meal trays in their room on the B-Hall, 9 residents who receive meal trays on the C-Hall, and 10 residents who receive meal trays in their room on the D-Hall. The findings are: 1. A review of the Order Summary Report, indicated Resident #34 had diagnoses that included chronic obstructive pulmonary disease and essential hypertension. a. The Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 03/20/2024 revealed Resident #34 had a Brief Interview for Mental Status (BIMS) score of 13 which indicated the resident was cognitively intact. b. On 05/28/2024 at 10:50 AM, the Surveyor asked Resident #34, Do you eat in your room all the time? Resident #34 stated, Yes. The Surveyor then asked, Is the hot food hot when you get your tray from the kitchen? Resident #34 stated, The food is always cold when it gets to my room. 2. The facility recipe for lima beans documented to use 1/2 cup plus 2 tablespoons stock chicken/soup base in preparation. On 05/28/2024 at 11:39 AM, Dietary Cook (DC) #1 used a 4 ounce (oz) spoon to put two servings of lima beans into a blender, then used the 4 oz spoon to add tap water, twice, to the beans and puree. 3. The facility recipe for meatloaf documented to use 1/2 cup plus 2 tablespoons (TBSP) water or stock in preparation. a. On 05/28/2024 at 11:44 AM, DC #1 placed two servings of meatloaf into the blender, then used 4 ounces (1/2 cup) spoon to add tap water, twice, for a total of 1 cup of tap water and pureed. b. At 05/28/2024 at 01:28 PM, the Surveyor asked the Activity Director to taste meatloaf served to the resident on puree diet. She did so and stated the meatloaf did not taste salty and required more salt, it is bland. 4. A review of the Order Summary Report, indicated Resident #13 had a diagnosis of diabetes mellitus. a. A Quarterly MDS with an ARD of 03/08/2024 documented a BIMS score of 9 (08-12 indicates moderately impaired). (continued on next page)

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	045157	A. Building B. Wing	05/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
River Ridge Rehabilitation and Care Center	1100 East Martin Drive Wynne, AR 72396

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	b. On 05/28/2024 at 11:51 AM, Resident #13 confirmed that eating their meals in their room, and that meals arrived cold. 5. The recipe for the puree dinner roll indicated 1/2 cup plus 2 TBSP of water or milk to be used in preparation. To thicken the dinner, roll 1 TBSP plus 3/4 teaspoon to be used in preparation. a. On 05/28/2024 at 12:09 PM, DC #1 placed 2 slices of white bread into a blender, used a 4 ounce spoon to add 2 servings of tap water on the bread, then added 2 tablespoons of thickener and pureed. b. On 05/28/2024 at 1:28 PM, the Activity Director stated the meatloaf did not taste salty and required more salt. 6. On 05/29/2024 at 11:01 AM, the Surveyor asked DC #1, how much water was used when pureeing meatloaf, lima beans, and bread, and what would be the best way to maintain the nutritive value when pureeing food items? DC #1 stated, I used one cup of water each. Milk and broth off the meat. DC #1 was asked how the food tastes when using water to puree. DC #1 stated, It would not taste as good as it should be. 7. On 05/29/2024 at 7:27 AM, an unheated cart that contained 9 breakfast trays was delivered to the A- hall by Certified Nursing Assistant (CNA) #5. At 07:36 AM, immediately after the last resident received tray in their room on A Hall, the temperature of test food items on the tray were checked and read by the CNA #5 with the following results: a. Scrambled eggs - 105 degrees Fahrenheit. b. Ground sausage with gravy - 104 degrees Fahrenheit. 8. On 05/29/2024 at 07:40 AM, an unheated cart that contained 16 breakfast trays for both B and C halls, was delivered to B hall by CNA #6. On 05/29/2024 at 07:50 AM, the food cart was then delivered to the C Hall by CNA #6. At 07:56, immediately after the last resident received their tray in their room on the C Hall, the temperature of food items on the test tray from the cart were checked and read by CNA #6 with the following results: a. Milk - 55 degrees Fahrenheit. b. Sausage - 91 degrees Fahrenheit. c. Scrambled eggs - 105 degrees Fahrenheit. d. Ground sausage with gravy - 103 degrees Fahrenheit. 9. On 05/29/2024 at 07:52 AM, an unheated cart that contained 10 breakfast trays was delivered to the D Hall. At 08:02 AM, immediately after the last resident received their tray in their room on D Hall, the temperature of food items on the test tray from the cart were checked and read by CNA #6. The temperatures were: a. Milk - 52 degrees Fahrenheit. (continued on next page)

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	045157	A. Building B. Wing	05/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
River Ridge Rehabilitation and Care Center	1100 East Martin Drive Wynne, AR 72396

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	b. Sausage - 95 degrees Fahrenheit. c. Scrambled eggs - 96 degrees Fahrenheit.

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	045157	A. Building B. Wing	05/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
River Ridge Rehabilitation and Care Center	1100 East Martin Drive Wynne, AR 72396

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. 03508 Based on observation and interview, the facility failed to ensure pureed food items were blended to a smooth, lump-free consistency to minimize the risk of choking or other complications for residents who required pureed diets for 2 of 2 meals observed. This failed practice had the potential to affect 1 resident who received a pureed diet. The findings are: 1. On 05/28/2024 at 11:44 AM, Dietary Cook (DC) #1 placed two servings of meatloaf into the blender, then used a 4 ounce spoon to add tap water twice and pureed. DC #1 poured the pureed meatloaf into a pan and placed it on the steam the steam. The consistency of the pureed meat loaf was lumpy and was not smooth. At 01:26 PM the surveyor asked the Activity Director to describe the consistency of the pureed meatloaf served to the resident on a puree diet. She stated, It looks chunky. 2. On 05/29/2024 at 12:49 PM, puree cubed steak, served to the resident on a pureed at lunch, contained clumps. The cabbage was not smooth and contained clumps. The surveyor asked the Activity Director to describe the consistency of the pureed food items served to the resident on puree diet. She stirred the cubed steak and stated, It is thick and stringy. 3. On 05/29/2024 at 12:50 PM, the surveyor asked Certified Nursing Assistant (CNA) #8 to describe the consistency of the meat and cabbage. CNA #8 stated, It is thick and gritty.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045157	A. Building B. Wing	05/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 03508 Based on observation and interview, the facility failed to ensure (1) that the kitchen floor, wall and ceiling tiles were cleaned and free of stains, chipped, grease and paint peeling to provide a sanitary environment for food preparation, (2) food items stored in the refrigerator, freezer, and storage area were covered or sealed, (3) expired dressing were promptly removed from stock to prevent potential food borne illness for residents who received meal trays from I of 2 kitchen, (4) the ice machine was maintained in clean and sanitary condition, and (5) dietary staff washed their hands before handling clean equipment or food items to prevent potential food borne illness for residents who received meals from 1 of 1 kitchen. These failed practices had the potential to affect 63 residents who received meals from the kitchen. The findings are: 1. On [DATE] at 10:15 AM, the following observations were made in the kitchen. a. At the entrance door to the kitchen area, the floor between the ice machine and air vent had rust stains. b. The floor between the oven and deep fryer had grease build up and the body of the deep fryer and oven had grease build up. c. Inside the deep fryer, the shelf had an accumulation of loose, greasy, dark brown, food crumbs covering the whole surface. d. The corners inside the food preparation sink had sage color settled on them. e. The wall above the food preparation sink was discolored a rust color and cracked. f. The window above the food preparation sink was cracked and there were gnats flying around the window. g. The wall between the food preparation counter to the handwashing sink was cracked and discolored with rust-colored stains around it. h. The ceiling tile between the milk refrigerator and dry goods rack was chipped, exposing the cement and concrete and the area was sage color. i. Wall inside the janitor's closet was cracked, discolored sage color around the area. j. The door leading to the walk-in refrigerator had rust stains. k. The wall above the fire extinguisher had paint peeling, exposing the brown colored fiber board. l. The wall behind the water hose in the dish machine had red, black and sage color stains. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045157	A. Building B. Wing	05/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
River Ridge Rehabilitation and Care Center	1100 East Martin Drive Wynne, AR 72396

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	m. The floor where the metal bar was attached to the steam table had thick brownish rust on it. n. The floor area around the 2 poles attached to the steam table had rust. 2. On [DATE] at 10:17 AM, there were loose tea and coffee filters on top of a box, below the food counter where the tea and coffee machines are kept. Dietary Cook (DC) #1 was asked what those are used for. DC #1 stated, The big ones are for the tea and the small ones are for the coffee. 3. On [DATE] at 10:24 AM, Dietary Aide #2 used a water hose to spray left over food particles out of the dishes, then placed the dishes on the rack and pushed it inside the dish machine. Without washing his hands, he picked up the plates with his bare hand and dried them with a rag and sat on a cart to be used in portioning food items to be served to the residents for lunch. This Surveyor immediately asked Dietary Aide #2, What should you have done after touching dirty objects and before handling clean equipment? Dietary Aide #2 stated, I should have washed my hands. 4. On [DATE] at 10:26 AM, the following observations were made in the walk-in refrigerator: a. An open box of sausage was on the shelf in the walk-in refrigerator, the box was not covered or sealed. b. An open box of bacon was on the shelf in the walk-in refrigerator, the box was not covered or sealed. 5. On [DATE] at 10:28 AM, an open box of garlic bread was on a shelf in the walk-in freezer, the box was not covered or sealed. 6. On [DATE] at 10:30 AM, Dietary Aide #2 used a water hose to spray left over food particles out of the dishes, then placed the dishes on the rack and pushed it inside the dish machine without washing their hands. After the machine stopped Dietary Aide #2 moved to the clean area, and without washing his hands picked up the glasses at the rim that touches the mouth, stacked them on the tray to be used for the residents during the noon meal. 7. On [DATE] at 10:37 AM, the seams of the milk refrigerator had white, black, and brown residue on them. At 1:28 PM, the Activity Director was asked to wipe the residue observed on the seams of the milk refrigerator. The Activity Director wiped the seams and a white, black, brown residue easily transferred to the tissue. The Activity Director was asked to describe what was found. The Activity Director stated, It is mildew. 8. On. [DATE] at 11:03 AM, the following observations were made in the dry storage room: a. An open container of parmesan cheese was on a shelf in the dry storage room. There was no received or open date on the container to ensure first in and first out. There were two additional open containers of parmesan cheese that did not have an open date. b. There was an open bottle of Hershey, with an open date of [DATE], the manufacturer specification documented Refrigerate after opening. (continued on next page)

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	045157	A. Building B. Wing	05/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
River Ridge Rehabilitation and Care Center	1100 East Martin Drive Wynne, AR 72396

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	c. A box that contained 45 individual packages of gluten free, thousand island dressing, was on a shelf and had an expiration date of [DATE]. 9. On [DATE] at 11:36 AM, Dietary Cook #1 pushed the blender motor toward the edge of the food preparation counter. Without washing her hands, she picked up the blade and attached it to the base of the blender to be used in pureeing items to be served to 1 resident on puree diet. As she was about to pour lima bean into a blender the Surveyor immediately stopped her and asked, What should you have done after touching dirty objects and before handling clean equipment? Dietary Cook #1 stated, I should have washed my hands.- 10. On [DATE] at 11:57 AM, Dietary Aide #2 turned on the food prep sink faucet by the drink area and obtained water in a pitcher and placed it on the counter. She then used her bare hand to turn off the faucet contaminating them. Without washing her hands, she picked the glasses by their rims and placed them on the trays to be used in serving beverages to the residents for lunch. The Surveyor asked, What should you have done after touching dirty objects and before handling clean equipment or food items? She stated, I should have washed my hands. 11. On [DATE] at 12:50 PM, Dietary Cook #1 who was on the tray line serving noon meal picked up the tray cards and placed them on a shelf above the steam table. Without washing her hands, she picked up the plates to be used in portioning food items to serve the residents with her fingers inside of the plates. She picked up the hot dog bun and separated it with her bare hands, before placing hot dog between the bun to be served to the resident who requested for it. 12. On [DATE] at 12:30 PM, the top panel of the ice machine had wet black residue on it. The Surveyor asked the Activity Director to wipe off the black/rusty residue on the panel with a paper towel. She did so, and the black/substance easily transferred to the paper towel. The Activity Director stated, It had black/brown residue. The surveyor asked, Who used the ice from the Ice Machine and how often do you clean the ice machine. The Dietary Supervisor stated, That's the ice the CNAs use for the water pitchers in the residents' rooms, I don't know who is responsible to clean it. 13. A facility policy titled Hand Washing documented, Before starting work: Always wash hands before beginning any food-related tasks. After touching anything else, such as dirty equipment, work surfaces, or cloths: Regularly clean hands to prevent cross-contamination.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 48630 Based on observations, interviews, record review, facility document review, and facility policy review, the facility failed to perform hand hygiene during resident care to prevent the spread of bacteria for 1 (Resident #9) of 1 resident reviewed for incontinent care. Findings include: A review of the Order Summary Report, indicated Resident #9 had diagnoses that included morbid (severe) obesity due to excess calories, dysuria, and urinary tract infection. The Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 04/08/2024 revealed Resident #9 had a Brief Interview of Mental Status (BIMS) score of 14 which indicated the resident was cognitively intact. The MDS indicated the resident was substantial/maximal assistance with toileting hygiene. A review of Resident #9's Care Plan, revised 04/19/2024, revealed the resident is at risk for impaired skin integrity r/t (related to) incontinence, impaired mobility, obesity, circulatory issues associated with atherosclerotic heart disease, scoliosis, and DM (diabetes mellitus). Interventions included provide incontinent/peri-care after each incontinent episode and as needed dated 07/09/2019. During an observation on 05/31/2024 at 11:32 AM, Certified Nursing Assistant (CNA) #12 was performing incontinence care for Resident #9. CNA #12 entered and immediately applied gloves; hand hygiene was not observed by the Surveyor. The brief was loosened, and the resident was positioned to the resident's left side. The incontinent stool was removed by CNA #12 with disposable wipes. Licensed Practical Nurse (LPN) #10 instructed the CNA to change gloves. CNA #12 changed gloves; hand hygiene was not performed. CNA #12 noted more stool, cleansed with disposable wipes. LPN #10 instructed CNA #12 to change gloves; hand hygiene was not performed with glove change. CNA #12 removed barrier cream from bedside nightstand and applied to sacrum. Placed brief on resident and repositioned resident. Removed gloves when finished placed in trash bag and took bag down the hallway and disposed of the trash. This Surveyor never observed CNA #12 perform hand hygiene before going down a different hall. During an interview on 05/31/2024 at 01:56 PM, the CNA #12 confirmed to the surveyor that hand hygiene was not performed during incontinent care and that hand hygiene should have been performed with each glove change, prior to gloves applied, and once the gloves were removed. CNA #12 added hand hygiene should have been performed to prevent the spread of germs from resident to resident. During an interview on 05/31/2024 at 02:30 PM, the LPN #10 confirmed no hand hygiene was performed during incontinent care and staff should perform hand hygiene when hands become soiled, and when switching from clean to dirty. LPN #10 stated hand hygiene is performed to prevent the spread of germs. During an interview on 05/31/2024 at 02:40 PM, the Director of Nursing (DON) stated gloves should be changed once in contact with a soiled surface and hand hygiene is to be performed between glove changes. The DON added hand hygiene is the first line of infection prevention and prevents the spread of infection. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility's undated policy titled, Hand Hygiene, indicated, Hand hygiene is any method that removes or destroys microorganisms on hands that includes handwashing and alcohol-based hand rubs. Perform hand hygiene when: 1. Before having direct contact with patients. 2. After contact with blood, body fluids, or excretions, mucous membranes, non-intact skin, or wound dressings. 3. After contact with patient's intact skin. 4. If hands will be moving from a contaminated-body site to clean-body site during patient care. 5. After contact with inanimate objects in immediate vicinity of the patient. 6. After removing gloves.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37925 Based on record review and interview, the facility failed to ensure the antibiotic stewardship program was consistently implemented as evidenced by a resident was prescribed an antibiotic for a suspected urinary tract infection (UTI) that did not meet selected criteria for 1 (Resident #26) of 1 sampled resident reviewed for a UTI. The findings are: Per an Order Summary Report, Resident #26 had a diagnosis of urinary retention. The Infection Surveillance Monthly Report for April 2024 showed Resident #26 had a symptom of weakness that started on 04/13/2024 and was prescribed Macrobid for a UTI on 04/14/2024. The [name] Criteria showed two of the following must be met for a resident with an indwelling catheter: fever, new flank, or suprapubic pain/tenderness, change in character of urine, or worsening of mental or functional status. An Advance Practice Registered Nurse (APRN) documented on an encounter note that Resident #26's appointment date and time was 04/11/2024 at 8:39 AM, and the resident was alert and resting in bed. The APRN documented Resident #26 had a [brand name] catheter present and reported no fever or abdominal pain. For mental status, the APRN documented resident #26 was oriented to time, place, and person. An Administration Note dated 04/13/2024 at 2:00 PM showed, .UA [urinalysis] send to [name] .UA sent to [local hospital] .d/t [due to] [name] not running on weekends . A Laboratory Report dated 04/13/2024 showed the test was a urine source with a result of [brand name] cath (catheter) and there was 1+ (plus) bacteria in the urine with a reference of 0-trace. On the bottom lower right of the report, the following information was written, 4-14-24 Macrobid 100 mg 1/1 PO [by mouth] BID [twice a day] x [times]10 days. [prescribing physician] A Physician's Order dated 04/14/2024 documented, Macrobid Oral Capsule 100 MG (milligrams) .give 1 capsule by mouth two times a day for UTI for 10 days . (Macrobid is an antibiotic.) On 05/31/2024 at 4:15 PM, the Nurses Notes were reviewed for 04/04/2024 to 04/12/2024 and there was no documentation of flank or suprapubic pain or tenderness, fever, change in urine, or worsening of mental or functional status. On 05/31/2024 at 4:27 PM, Resident #26's temperature summary was reviewed in the electronic health record and there were no elevated temperatures documented for the time period between 03/28/2024 to 04/16/2024. (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 05/31/2024 at 4:54 PM, the Assistant Director of Nursing/Infection Preventionist (ADON/IP), was interviewed and asked what does she do to ensure a resident who has been prescribed an antibiotic needs it. She stated there was an antibiotic stewardship form. She confirmed this form was done for Resident #26 for an antibiotic prescribed in April of 2024. She was asked if the pharmacist made any recommendations on this form, and she stated no. She was asked if she fills out the [name] criteria form when a resident is placed on an antibiotic and she confirmed she did and added, I did do this and I documented no, that it did not meet criteria. I spoke with the doctor, but he documented the urine was cloudy and a diagnosis of urinary retention and that's all. She was asked to look at the form under the information needed under a UTI with a catheter. She confirmed that a diagnosis of urinary retention was not listed under the criteria. On 05/31/2024 at 5:07 PM, the ADON/IP provided a copy of a Pharmacy MRR (Medication Regimen Review) Antibiotic Stewardship form that only included the data from section B. The IP documented no culture and sensitivity was ordered and that this was not a true infection. She documented the urinalysis was reviewed by the medical doctor with an antibiotic prescription given due to the urine appearance was cloudy and a diagnosis of urinary retention. The Infection Prevention and Control Program policy provided by the administrator on 05/28/2024 with a copyright date of 2022 documented, .Antibiotic Stewardship: Antibiotic use protocols and a system to monitor antibiotic use will be implemented as part of the antibiotic stewardship program . An Antibiotic Stewardship policy with no date documented, .Staff will utilize the [name] Criteria when considering initiation of antibiotics and for determination of suspected infections in residents .