STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045166	A. Building B. Wing	04/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Crestpark Wynne, LLC	400 Arkansas Street 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 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident when there is a significant change in condition 44852 Based on record review and interview, the facility failed to ensure a change of condition assessment was completed no later than 14 days after the significant change for 1 (Resident #30) of 1 sampled resident. The findings are: 1. Resident #30 had a diagnosis of Unspecified dementia without behavioral disturbance. a. The resident's medical record revealed a Physician's Order for admission to Hospice was received on 03/26/2024. The last Minimum Data Set (MDS) completed was a Quarterly assessment with an Assessment Reference Date (ARD) of 12/04/2023. No Significant Change assessment was present in the medical record. b. On 04/11/2024 at 08:20 AM, the MDS Coordinator was asked if she was aware Resident #30 was admitted to Hospice. The MDS Coordinator reported that she hadn't reviewed the dates and claimed responsibility for the oversight. The MDS Coordinator was asked how she was made aware of changes in a resident's status. The MDS Coordinator described reviewing the orders every day along with the 24 hour reports. The MDS Coordinator confirmed that the facility does not have a daily stand up meeting to discuss changes in resident status. c. The Centers for Medicare & Medicaid Services (CMS) Resident Assessment Instrument (RAI) Version 2.0 manual documented, .Chapter 2: The assessment Schedule for RAI .Significant change in status assessments (SCSA)-Comprehensive Assessment .If the condition does not return to baseline, the assessment should be completed as soon as needed to provide appropriate care to the resident, but in no case later than 14 days after the determination was made that a significant change occurred .

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

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Encode each resident's assessment data and transmit these data to the State within 7 days of assessment. 44852 Based on interview and record review, the facility failed to ensure a Quarterly Minimum Data Set (MDS) was transmitted in a timely manner to promote individualized care for 2 (Residents #7 and #13) of 2 sampled residents. The findings are: On 04/10/2024 at 11:10 AM, a Quarterly Minimum Data Set (MDS) for Resident #7 and Resident #13 were identified as being 120 days late. On 04/10/2024 at 01:30 PM, the MDS Coordinator was asked to review the last MDS assessments which were submitted for Resident #7 and #13. The MDS Coordinator reported Resident #7 had a Quarterly MDS which was submitted on 02/01/2024 and Resident #13 had a Quarterly assessment submitted on 02/21/2024. The MDS Coordinator describes the facility computer system as revealing the assessments were submitted and received. The MDS Coordinator displayed paper confirmation which confirmed the submission and receipt. The MDS Coordinator shared that another person was responsible for completion and submission of MDS assessments during the month of February. The MDS Coordinator verbalized her plan to look on the CMS website to ensure the submissions were complete. On 04/11/2024 at 08:10 AM, the MDS Coordinator reported that CMS (Centers for Medicare & Medicaid Services) was contacted, and it was determined that the MDS assessments in question were not submitted/accepted as previously thought. The MDS Coordinator confirmed that the assessments were late and were resubmitted on the evening of 04/10/2024. The MDS Coordinator provided an MDS 3.0 NH (Nursing Home) Final Validation Report which confirmed reception, receipt, and acceptance on 04/11/2024. When the MDS Coordinator was asked how the facility would have known that there had been an issue with the transmission of assessments completed in February. The MDS Coordinator stated that she wouldn't have known until the next assessment was completed had it not been for the attention called to the problem during this survey. On 04/11/2024 at 02:21 PM, the Director of Nursing (DON) provided, Ch [Chapter] 5: Submission and Correction of the MDS Assessments, page 5-3. It documented, Assessment Transmission: Comprehensive assessments must be transmitted electronically within 14 days of the Care Plan Completion Date. All other MDS Assessments must be submitted within 14 days of the MDS completion Date.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 38200 Based on observation, interview and record review, the facility failed to ensure hand rolls were applied to prevent further decline in range of motion (ROM) for 2 (Residents #13 and #28) of 3 sampled residents. The findings are: 1. A review of Resident #13's Care Plan dated 05/26/2023 did not document the contracture to the left hand. a. A review of Resident #13's Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 02/21/2024 noted the resident was impaired on one side of the upper extremities. b. On 04/09/2024 at 11:17 AM, the Surveyor observed Resident #13 lying in bed at a fifteen (15) degree angle on his/her left side with legs elevated under the blanket. Resident #13 had a left hand contracture with no device present. c. On 04/09/2024 at 02:24 PM, the Surveyor observed Resident #13 lying on his/her back in bed at a fifteen (15) degree angle. The left hand remained contracted with no device present. d. On 04/10/2024 at 12:58 PM, the Surveyor observed Resident #13 lying in bed. The left hand was contracted with no device present. e. On 04/10/2024 at 01:04 PM, Certified Nurse Assistant (CNA) #3 confirmed that Resident #13's left hand was contracted with no device present to prevent the contracture from getting worse. f. On 04/10/2024 at 01:17 PM, the Director of Nursing (DON) confirmed that Resident 13's left hand was contracted with no device present to prevent the contracture from getting worse. 2. A review of Resident #28's Care Plan dated 12/19/2023 did not document the contracture to the left hand. a. A review of Resident #28's Quarterly MDS with an ARD of 02/14/2024 noted the resident was impaired on both sides of the upper extremities. b. On 04/10/2024 at 01:10 PM, the Surveyor interviewed CNA #3 at Resident #28's bedside and had her pull the residents blanket back to expose the extremities. CNA #3 confirmed the resident had a left hand contracture with no device present to prevent the contracture from getting worse. c. On 04/10/2024 at 01:20 PM, the Surveyor interviewed the DON at Resident #28's bedside. The DON confirmed the resident had a left hand contracture with no device present to prevent the contracture from getting worse. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	d. On 04/11/2024 at 09:22 AM, the Surveyor interviewed the Minimum Data Set (MDS) Coordinator and asked, If a resident is admitted to the facility with a contracture should it be documented on their comprehensive care plan? She stated, Yes, ma'am. When asked, Why should a contracture be on the care plan? She stated, It has to do with ADLs [activities of daily living] and help they may need. They may need a hand roll to prevent it from getting worse.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. 38200 Based on interview and record review, the facility failed to ensure a resident's individualized plan of care was revised to reflect the current needs of the resident and updated to include falls for 1 (Resident #13); oxygen therapy for 1 (Resident #19); and Hospice services for 1 (Resident #30) sampled residents. The findings are: 1. Resident #13's Care Plan dated 05/26/2023 did not document the contracture to Resident #13's left hand. a. A review of Resident #13's Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 02/21/2024 noted the resident was impaired on one side of both the upper and lower extremities and had had no falls. b. An Incident report dated 03/05/2024 noted Resident #13 was found lying on the floor next to the bed. 2. A review of Resident #19's Care Plan dated 05/19/2023 did not document oxygen use. a. A review of Resident #19's Physician Orders dated 02/06/2024 noted oxygen saturation QS (as frequently as needed) keep at or above 93%. No specific order for quantity of oxygen in liters. b. A review of Resident #19's Medication Administration Record (MAR) for April 2024 documented oxygen usage at two (2) liters as needed for shortness of breath or below 93% O2 (oxygen) on 04/01/2024; 04/02/2024; 04/05/2024; 04/06/2024; 04/08/2024; and 04/09/2024. 44852 3. Resident #30 had a diagnosis of Unspecified dementia without behavioral disturbance. a. A Physician's Order for admission to Hospice was received on 03/26/2024. The order also included the discontinuation of all medications except PRN (as needed) and comfort. On 04/10/2024, a review of Resident #30's medical record revealed a physician's order for admission to Hospice was received on 03/26/2024. A review of Resident #30's care plan revealed that the care plan had not been revised to include Hospice services. b. On 04/11/2024 at 08:20 AM, the MDS Coordinator was asked when a care plan should be updated. The MDS Coordinator reported that a comprehensive care plan should be updated quarterly and as needed. When asked for as needed examples, the MDS Coordinator cited falls, major medication changes. When asked if the discontinuation of all medications which included antidepressants and antipsychotics would be considered a major medication change, the MDS Coordinator confirmed it would. When asked why updating the care plan would be important in this instance, the MDS Coordinator described that the staff would need to know to look for changes in mood or behavior. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. The facility provided a policy titled, 'CMS's [Centers for Medicare & Medicaid Services] RAI [Resident Assessment Instrument] Version 3.0 Manual,' dated October 2023, that documented, .Following the decision to address a triggered condition on the care plan, key staff or the IDT [Interdisciplinary Team] should subsequently: Review and revise the current care plan, as needed; and Communicate with the resident or their family or representative regarding the resident, care plans, and their wishes .

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. 38200 Based on observation, interview and record review, the facility failed to ensure residents were shaved to promote good personal hygiene for 2 (Residents #13 and #3) of 2 sampled residents and residents' fingernails were kept clean for 1 (Residents #3) of 1 sampled resident. The findings are: 1. A review of Resident #13's Plan of Care dated 05/26/2023 noted the resident required total assistance with activities of daily living (ADLs). a. The facility provided a policy titled, 'Please Be Careful When Shaving Residents. Do Not Rush Through, As This Can Lead To Nicks & Cuts', dated 12/15/2023, which documented, Overview: Shaving may help a person feel good. b. A review of Resident #13's Physician Orders dated 02/09/2024 documented, Shower 6-2 bed baths daily may give shower if needed/ as tolerated. c. A review of Resident #13's Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 02/21/2024 noted the resident was dependent for showers/baths. d. On 04/09/2024 at 11:17 AM, the Surveyor observed Resident #13 lying in bed. The resident needed to be shaved. e. On 04/09/2024 at 02:24 PM, the Surveyor observed Resident #13 lying in bed. The resident's face was not shaven. f. On 04/10/2024 at 12:57 PM, the Surveyor observed Resident #13 lying in bed. Resident #13 was unshaven. g. On 04/10/2024 at 01:04 PM, the Surveyor interviewed Certified Nursing Assistant (CNA) #3 at Resident #13's bedside. CNA #3 confirmed the resident was not clean shaven and should have been shaved on bath day. h. On 04/10/2024 at 01:15 PM, the Surveyor interviewed the Director of Nursing (DON) who confirmed the resident was not clean shaven and should have been shaved on bath day. 2. Resident #3 had diagnoses of Unspecified sequelae of cerebrovascular accident and Unspecified atrial fibrillation. a. A Quarterly MDS with an ARD of 01/15/2024 documented Resident #3 scored 13 (13-15 indicates cognitively intact) on a Brief Interview for Mental Status (BIMS) and was dependent for care. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	b. Resident #3's Care Plan documented, The resident is at risk of developing complication r/t [related to] needing total assistance in the following ADLS [activities of daily living]: bed mobility, transfer, locomotion, dressing, personal hygiene, bathing, and toilet use . Approaches. Nailcare every two weeks per nurse . c. On 04/09/2024 at 12:26 PM, Resident #3's chin had hair that was stubble like in appearance. The Surveyor observed the fingernails of both hands had a brown substance under them, and the nails were long, jagged, and chipped in appearance. Resident #3 said they do not pluck my hair on bath days, and I would like that. Resident #3 also stated that the resident would like their fingernails cleaned and clipped. e. On 04/09/2024 at 02:21 PM, the Surveyor asked Resident #3 if nail care and plucking had been provided. Resident #3 showed the Surveyor the resident's chin and hands. The Surveyor observed no changes. Resident #3 stated it had not. f. On 04/10/2024 at 01:34 PM, the Surveyor asked CNA #2 to described Resident #3's hands. CNA #2 said that the nails were long and dirty and that they needed to be clipped. The Surveyor asked for CNA #2 to describe Resident #3's chin. CNA #2 said that the hair needs to be plucked or shaved. The Surveyor asked what the issue for the resident could be. CNA #2 said that it could be a dignity issue. The Surveyor asked when should nail care and shaving be done. CNA #2 said as needed, and to tell the nurse if the resident is diabetic. g. On 04/10/2024 at 01:43 PM, the Surveyor asked Licensed Practical Nurse (LPN) #1 to describe Resident #3's hands. LPN #1 said that the nails need clipping and are dirty. The Surveyor asked what the issue for the resident could be. LPN #1 said that the resident could scratch herself. The Surveyor asked LPN #1 to describe Resident #3's chin. LPN #1 said that yes, they need plucked or shaved. The Surveyor asked when should nail care and shaving be done. LPN #1 said when you see it and bathe them. 49689

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. 38200 Based on observation, interview and record review, the facility failed to ensure hand rolls were applied to prevent further decline in range of motion (ROM) for 2 (Residents #13 and #28) of 3 sampled residents. The findings are: 1. A review of Resident #13's Care Plan dated 05/26/2023 did not document the contracture to the left hand. a. A review of Resident #13's Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 02/21/2024 noted the resident was impaired on one side of the upper extremities. b. On 04/09/2024 at 11:17 AM, the Surveyor observed Resident #13 lying in bed. Resident #13 had a left hand contracture with no device present. c. On 04/09/2024 at 02:24 PM, the Surveyor observed Resident #13 lying in bed. The left hand was contracted with no device. d. On 04/10/2024 at 12:58 PM, the Surveyor observed Resident #13 lying in bed. The left hand was contracted with no device present. e. On 04/10/2024 at 01:04 PM, the Surveyor interviewed Certified Nursing Assistant (CNA) #3 at Resident #13's bedside. CNA #3 confirmed the resident's left hand was contracted with no device present to prevent the contracture from getting worse. f. On 04/10/2024 at 01:17 PM, the Surveyor interviewed the Director of Nursing (DON) at Resident #13's bedside. The DON confirmed the resident's left hand was contracted with no device present to prevent the contracture from getting worse. 2. Resident #28's Care Plan dated 12/19/2023 did not document the contracture to the left hand. a. A review of Resident #28's Quarterly MDS with an ARD of 02/14/2024 noted the resident was impaired on both sides of the upper and lower extremities. b. On 04/10/2024 at 01:10 PM, the Surveyor interviewed CNA #3 at the resident's bedside and had her pull the residents blanket back to expose the extremities. CNA #3 confirmed Resident #28 had a left hand contracture with no device present to prevent the contracture from getting worse. c. On 04/10/2024 at 01:20 PM, the Surveyor interviewed the DON at the resident's bedside. The DON confirmed that Resident #28 had a left hand contracture with no device present to prevent the contracture from getting worse. 49689 (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. A review of the facility policy titled, Restorative/Rehab [Rehabilitation] Care stated in part, the goals of rehab/restorative care are to maintain the present level of function and to improve or restore physical function.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38200 Based on observation, interview, and record review, the facility failed to ensure fall mats at the bedside were properly positioned for 1 (Resident #13) of 1 sampled resident who required fall mats and call lights were maintained with no exposed wires for 1 (Resident #11) of 1 sampled resident. The findings are: 1. Resident #13 was admitted on [DATE] with a diagnosis of Alzheimer's disease and Convulsions. a. A facility in-service titled, 'Falls: Reduce the Risks' dated 05/19/2023 documented, .Intervention & Documentation Tickler for Falls . Padding on floor- landing mat(s) . b. The facility provided an Incident and Accident (I&A) Report dated 03/05/2024 that noted Resident #13 had fallen and hit the right side of their forehead on the floor. The twenty-four (24) hours follow up noted fall mat placed, staff re-educated to lower head of bed (HOB). c. Review of Resident #13's Care Plan dated 05/26/2023 did not document a fall. d. On 04/09/24 at 11:17 AM, the Surveyor observed Resident #13 lying in bed. Resident #13 had a fall mat that was positioned underneath the bed. e. On 04/10/2024 at 12:55 PM, the Surveyor observed Resident #13 lying in bed. Resident #13's fall mat was underneath the bed. f. On 04/10/2024 at 01:04 PM, Certified Nursing Assistant (CNA) #3 confirmed the resident was at risk for falls and the fall mat was underneath Resident #13's bed and should be located on the side of the resident ' s bed. g. On 04/10/2024 at 01:13 PM, the Director of Nursing (DON) confirmed the resident was a fall risk and the fall mat was underneath Resident #13's bed and should be located on the side of the resident's bed. h. A facility policy titled 'Accidents' documented, .The intent of this requirement is to ensure the facility provides an environment that is free from accident hazards over which the facility has control and provides supervision and assistive devices to each resident to prevent avoidable accidents. This includes: Identifying hazard(s) and risk(s); evaluating and analyzing hazard(s) and risk(s); Implementing interventions to reduce hazard(s) and risk(s) . 49689 2. On 04/09/2024 at 12:48 AM, the Surveyor observed a gray call light laying across Resident #11's bed, part of the plastic was missing exposing wires. The Surveyor then observed a cable cord hanging from the right-hand corner near the bathroom door. The cable was touching the floor. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	a. On 04/09/2024 at 02:22 PM, the Surveyor observed the resident moving around the room, no changes had been made to observations earlier. b. On 04/09/2024 at 02:33 PM, the Surveyor asked CNA #1 to describe the call light and what the issue could be for the resident. CNA #1 said that a plastic piece is missing, and that it could be a fire hazard. The Surveyor asked what the protocol for reporting issues like this was. CNA #1 said it should be written down on the maintenance log. The Surveyor then observed the CNA #1walk to the maintenance log for east hall and state it had not been reported, the Surveyor then observed them writing in it about the call light having wires exposed. c. On 04/09/2024 at 02:37 PM, the Surveyor asked the Maintenance Employee to observe the call light and asked what the issue could be for the resident. The Maintenance Employee said it has plastic broken off, and that it's an electrical issue. The Surveyor asked if it had been reported to them. The Maintenance Employee said it had not. The Surveyor asked about the cable in the corner of the room. The Maintenance Employee said that it was supposed to be covered and tucked into the ceiling. The Surveyor asked what the issue is with the cable being down. The Maintenance Employee said that it could be hazardous as they believe it's a live wire. The Surveyor asked if it has been reported to them. The Maintenance Employee said no it has not been reported. d. A facility policy titled Maintaining Call Lights documented, .Maintenance is responsible for ensuring that call lights are working/functioning properly. Call lights should be checked once a week. Staff should report any call lights that are not functioning properly to maintenance so that the issue can be resolved. Call light Checklist: C. Call light cords in good condition-no fraying or tears on cord .

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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** 44852 Based on observation, interview, and record review, the facility failed to ensure food items were sealed after opening, food items were used prior to their use by date, equipment was maintained in good condition, and pans and other containers were stored in a manner to minimize the risk of contamination. The findings are: On 04/09/2024 at 10:27 AM, a carton of potato flakes was observed on the top shelf, above the worktable in the kitchen. The mouth of the carton was open, exposing the food product to air and contaminants. On the lowest shelf a container of paprika was observed with the top open exposing the product to air and contaminants. On 04/09/2024 at 10:35 AM, 1 package of hot dog buns and 1 package of hamburger buns were observed on the top tray of the bread rack with a use by date of 04/05/2024. On the second tray there were 4 full loaves of sliced bread with a use by date of 04/05/2024. On 04/09/2024 at 10:40 AM, 4 stainless steel mixing bowls, 5 skillets, 4 sheet trays, 7 large trays, 3 1/2 steam table pans, 2 1/4 steam table pans and 9 large steam table pans were stored right side up in a manner which allow dust and contaminants to collect prior to use. The shelf was observed to contain multiple food particles which extended down the length of the shelf and were beside the pots, trays, and other items on the shelf. On the upper shelves a stack of 11 divided plates, 5 gallon pitchers and one large beverage dispenser were observed to be right side up allowing for the collection of dust and contaminants. On 04/08/2023 at 10:45 AM, 2 wire baskets used for deep frying were observed hanging from a pot rack in the middle of the room. The entire circumference of each basket was coated in a tan substance that was thick and sticky to touch. The substance extended 1 to 1.5 inches down the side and all the way up the handle of each basket. Several pots were observed to be dented and blackened on the bottom. On 04/08/2024 at 11:36 AM, Dietary Aide #1 was observed inserting a digital thermometer into a full steam table pan of baked beans. The thermometer was inserted into the beans all the way to the handle of the thermometer, the plastic end extending into the bean mixture 1/2 inch. On 04/08/2024 at 12:00 PM, seven tables were observed in the dining room. The legs of each table were observed to be covered in varying amounts of rust. On 04/11/2024 at 10:45 AM, the Director of Nursing (DON) provided a Food Safety and Sanitation Policy and Procedure. On page 2, the policy directs that stored food is handled to prevent contamination and growth of pathogenic organisms. When a food package is opened, the food item should be marked to indicate the open date; perishable foods with expiration dates are used prior to the use by date on the package. Note: .all food and dining areas should be inspected on a regular basis. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045166	A. Building B. Wing	04/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Crestpark Wynne, LLC	400 Arkansas Street Wynne, AR 72396

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 04/11/2024 at 11:15 AM, the Dietary Manager (DM) was asked how pots, pans and utensils should be stored. She replied that the items would typically be stored face down but the facility has a large rack for storing pots and pans. The DM was asked about the items on the bottom shelf and confirmed that the items are stored right side up but stated that the items should be face down. The DM identified the risk of gathering debris as the reason for storing these items bottom up. When asked how long the rust had been present on the shelves and legs of the worktables, the DM reported that the rust was present when she started working in the facility [AGE] years ago. The DM described how the staff took several pieces outside last year and painted the rusted shelves with paint designed for metal. However, the attempt at refurbishing isn't holding up as they had expected. She continued that the primary worktable located in the middle of the room that had the heaviest rust coverage, they were not able to get the table outside because the screws which hold the pot rack started to break when they attempted to take the rack down. The screws were corroded with grease and rust. When addressing the rack located beside the steam table that was rusted, the DM expressed that they would have been better served with a rubber coated rack versus the rack that is all metal. The DM confirmed that she was aware of the rust on the tables in the dining room. She was uncertain as to when the rust had developed, just that the rust had covered the legs of the tables for some time. When asked to describe the substance covering the circumference of the deep fryer the DM said the substance was a buildup of grease, a little crusty and slick. The DM reports that the facility has never had a deep fryer, as that would require the hood to be enlarged. Ensuring an item is dated and sealed was identified by the DM as the primary task when a food item is brought into the kitchen. On 04/12/2024 at 08:24 AM, the Administrator was asked if she was aware of the issues concerning the presence of rust on the kitchen equipment and on the legs of the dining room tables. The Administrator reported that they have been intending to take the tables outside to paint the legs. The Administrator was asked how long the tables had been in the facility, and the Administrator reported as long as she had been here, [AGE] years.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045166	A. Building B. Wing	04/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 49689 According to observation, interview and record review, the facility failed to ensure incontinence care waste was disposed of properly for one (Resident #26) sampled resident. The findings are: 1. A Face Sheet documented Resident #26 had diagnoses of Dementia, Delusional disorder, and Cognitive communication deficit. 2. A Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 04/02/2024 documented Resident #26 scored a 2 (0-7 indicates severe cognitive impairment) on the Brief Interview for Mental Status (BIMS). 3. A Care Plan for Resident #26 documented, Behavior, [Resident #26] wanders thru [through] out the facility, [Resident #26] will remove urostomy and emptied in different places, rummages through clothes in [Resident #26's] room. 4. On 04/09/2024 at 10:25 AM, the Surveyor observed Resident #26 wandering the halls, then enter the resident's room and began to rifle through the trash. The Surveyor observed that in the trash can was a soiled brief with a blue wetness indicator visible. Resident #26 touched the soiled brief. The Surveyor then observed Resident #26 leave the room and walk down the hall. Resident #26 touched the handrails in the hallways being utilized by other residents, interacted with staff members, and touched a chair by the nurse's station before sitting in it. The Surveyor observed two residents going by in wheelchairs, stopped to take breaks and touch the handrails in the hallway. Registered Nurse (RN #1) redirected Resident #26 to the resident's room, holding the Resident ' s hand while walking down the hall. 5. On 04/09/2024 at 10:30 AM, the Surveyor asked Registered Nurse (RN) #1 what was in Resident #26's trash can by the bed. RN #1 said there is a brief in the trash can and it should have been changed already after incontinence care was performed. The Surveyor observed RN #1 pulling the trash bag containing the soiled brief out and put a new one in. The Surveyor asked what the issue could be for soiled incontinence care products being left in the room with a cognitively impaired resident. RN #1 said the resident could get into it; the resident has severe dementia. 6. On 04/10/2024 at 01:35 PM, the Surveyor asked Certified Nursing Assistant (CNA) #2 if soiled briefs should be left in the trash can after incontinence care was performed. CNA #2 said that the brief should not have been left in there, as it's an infection control issue. 7. A facility training titled Incontinent Care/Foley Care Observation documented, .21. Clean-up workstation and place everything in appropriate bags .