STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045182	A. Building B. Wing	08/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Courtyard Rehabilitation and Health Center, LLC	2415 W Hillsboro El Dorado, AR 71730

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Reasonably accommodate the needs and preferences of each resident. 48977 Based on observations, interviews and record reviews, the facility failed to ensure the call device was within reach for 2 (Resident #8 and #63) sampled residents. The findings include: 1. According to Quarterly Minimum Data Set with the Assessment Reference Date 8/12/2024 Resident #8 had memory problems. Resident #8 had impairment on one side. A Care Plan (revision date 11/22/2021) revealed Resident #8 was at risk for falls due to non-ambulatory and mechanical lift. Approach/task documented keep call light within reach On 08/26/24 at 6:34 PM, the Surveyor observed Resident #8 lying in bed and the call device on floor out of the resident's reach. On 08/26/24 at 7:12 PM, the Surveyor observed Resident #8 lying in bed and the call device on floor out of the resident's reach. On 08/28/24 at 7:50 AM, the Surveyor observed Resident #8 lying in bed and the call device wrapped around the feeding pump out of the resident's reach. On 08/28/24 at 11:11 AM, the Surveyor observed Resident #8 lying in bed and the call device wrapped around the feeding pump out of reach the resident's reach. On 08/28/24 at 1:22 PM, the Surveyor observed Resident #8 lying in bed and the call device wrapped around the feeding pump out of reach the resident's reach. 2. According to Quarterly Minimum Data Set with the Assessment Reference Date 5/28/2024 Resident #63 had memory problems. Resident #63 did not have upper or lower extremities impairment. A Care Plan (revision date 8/27/2024) revealed Resident #63 was at risk for falls related to immobility and a history of falls. \On 08/26/24 at 7:42 PM, the Surveyor observed Resident #63 lying in bed and the call device clipped to the outlet on the wall out of the resident's reach. (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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045182	A. Building B. Wing	08/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Courtyard Rehabilitation and Health Center, LLC	2415 W Hillsboro El Dorado, AR 71730

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 08/26/24 at 8:52 PM, the Surveyor observed Resident #63 lying in bed and the call device clipped to the outlet out of the resident's reach. On 08/26/24 at 8:52 PM, the Director of Nursing (DON) stated the call device was not within reach of resident #63. On 08/28/24 at 2:27 PM, Licensed Practical Nurse #3 stated that the call device was not within reach of the Resident #8. On 08/29/24 at 8:32 AM, the DON stated the call device should be within reach of the resident in case the resident needs anything they can notify the staff. The DON voiced the call device not being within reach of the resident could contribute to falls and behaviors.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045182	A. Building B. Wing	08/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Courtyard Rehabilitation and Health Center, LLC	2415 W Hillsboro El Dorado, AR 71730

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 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. 48977 Based on record review, interviews and the facility failed to provide notice of discharge to 1 (Resident #76) sampled resident or the resident representative. The findings include: According to a Quarterly Minimum Data Set (MDS) with the Assessment Reference Date (ARD) 05/15/2024, Resident #76 had a Brief Interview of Mental Status score of 15, indicating cognitively intact and was a Medicaid recipient. A Care Plan (cancelled Date: 6/17/2024) revealed the Preadmission Screening and Resident Review identified that Resident #76 needed specialized services due to intellectual disability (ID). The specialized services would help achieve optimal functioning and recovery. A Nursing Note (dated 6/13/2024 at 12:53) noted the author spoke with the Director at behavioral facility and was able to get Resident #6 an appointment at 11. The facility notified the behavioral facility of the resident's behaviors at the facility. The behavior facility contacted a hospital and got the resident accepted there for his behaviors, and the resident was admitted . Review of the MDS with ARD of 6/13/2024 entry/discharge reporting showed discharge assessment-return not anticipated. On 08/28/24 at 12:08 PM, the Director of Nursing stated Resident #76 was threatening staff and residents, and the facility could not care for him. The DON stated the resident or resident representative was not provided with a notice of discharge.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045182	A. Building B. Wing	08/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Courtyard Rehabilitation and Health Center, LLC	2415 W Hillsboro El Dorado, AR 71730

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42965 Based on record review and interview, the facility failed to ensure an Annual Minimum Data Set (MDS) assessment was coded correctly to document a resident had a serious mental illness and or intellectual disability or related condition requiring level II PASARR (Preadmission Screening and Resident Review) to ensure continuity of care for 1 (Resident #9) sampled residents with a diagnosis of serious mental illness. The findings are: 1. The Annual Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 11/03/2023 indicated Resident #9 had diagnoses of depression, bipolar depression, and seizure disorder and scored 11(8 - 12 indicates moderate impairment) on the Brief Interview for Mental Status (BIMS). a. The Annual Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 11/03/2023 indicated, A1500 Preadmission Screening and Resident Review .Is the resident currently considered by the state level II PASRR process to have a serious mental illness and/or intellectual disability or related condition? 0. No . b. The Care Plan with a revision date of 07/11/2024 indicated Resident #9 uses antidepressant medication related to major depression and bipolar disorder. c. On 8/27/2024 at 3:10 PM, the Surveyor requested a copy of the residents complete PASARR (Preadmission Assessment Screening and Resident Review) packet from the Director of Nursing (DON). d. On 08/27/2024 at 3:20 PM, the Surveyor received the complete PASSAR packet dated May 3rd, 2013, from the Nurse Consultant that contained a letter dated May 3, 2013, from (name of state designated authority for PASARR determination) that indicated Resident #9 did not require specialized services for their mental illness beyond the capabilities of a nursing facility. e. On 08/28/24 at 09:15 AM, during an interview the MDS Coordinator stated Resident #9 had serious mental health diagnoses requiring a level II PASARR to be completed prior to the resident's admission to the facility and the Annual MDS dated [DATE] had been coded incorrectly. f. On 08/29/24 at 08:35 AM, the DON was asked if she had a policy on accuracy of MDS Assessments. g. On 08/29/24 at 09:20 AM, the policy titled Resident/Elder Assessment and Comprehensive Care Plan Procedure indicated, .Resident/Elder assessment. It is the policy of this nursing facility to conduct and document, initially and periodically, comprehensive assessments on all Residents/Elders admitted to the nursing facility. Comprehensive assessments of Residents/Elders functional capacity are accurate, and standardized. Comprehensive assessments describe the Resident/Elder's capability to perform daily living functions and significant impairment in functional capacity to provide the nursing facility with the information necessary to develop a care plan and to provide appropriate care and services for each Resident/Elder .

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045182	A. Building B. Wing	08/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Courtyard Rehabilitation and Health Center, LLC	2415 W Hillsboro El Dorado, AR 71730

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 - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 48977 Based on observations, interviews and record review, the facility failed to ensure that staff did not lower the head of the bed while 1 sampled (Resident #8) was receiving continuous enteral feeding. The finding include: According to Quarterly Minimum Data Set with the Assessment Reference date of 8/12/2024 Resident #8 had severely impaired cognition. Resident #8 had a feeding tube. A Care Plan (revision date 06/19/2024) revealed Resident #8 required Enhanced Barrier Precautions related to percutaneous endoscopic gastrostomy (PEG) tube. On 08/26/24 at 7:00 PM, the Surveyor observed Certified Nursing Assistant (CNA) #1 lower Resident #8's head of bed and both CNA #1 and #2 turn the resident from side to side while the enteral feeding was running. On 08/26/24 at 7:15 PM, CNA #2 confirmed the head of the bed was lowered while Resident #8's enteral feed pump was running. On 08/29/24 at 8:37 AM, the Director of Nursing (DON) stated staff should not lower the head of the bed when a resident is receiving eternal feeding They know better than that. The DON confirmed that turning a resident side to side while receiving eternal feeding could potentially cause aspiration. Review of policy titled Accident Hazards Prevention, undated, noted the facility is responsible for providing care to residents in a manner that helps promote quality of life.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045182	A. Building B. Wing	08/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Courtyard Rehabilitation and Health Center, LLC	2415 W Hillsboro El Dorado, AR 71730

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 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. 48977 Based on observations, interviews, and record reviews, the facility failed to ensure that incontinence care was provided in a manner to promote cleanliness for 1 (Resident #8) sampled resident. The findings include: According to a Quarterly Minimum Data Set with the Assessment Reference date of 8/12/2024 Resident #8 had severely impaired cognition. Resident #8 was always incontinent of bowel and bladder. A Care Plan (revision date 8/19/2021) revealed Resident #8 was incontinent of bowel and bladder related to (r/t) impaired mobility, diagnosis of chronic renal failure, and requires total care for Activities of Daily Living (ADLS). On 08/26/24 at 7:00 PM, the Surveyor observed Certified Nursing Assistant (CNA) #1 and #2 provide incontinence care to Resident #8, who had been incontinent of bowel and bladder. The Surveyor observed CNA #1 not clean the genital area or buttock correctly. On 08/26/24 at 7:15 PM, CNA #1 stated a portion of the genital area was not cleaned because the resident was too contracted. CNA #1 stated not cleaning the genital area properly could cause a urinary tract infection or there could be stool remaining on the resident. Both CNA #1 and #2 stated that incontinence care was not provided correctly. On 08/29/24 at 8:43 AM, the Director of Nursing (DON) confirmed incontinence care was not provided correctly if the genital area or buttock was not cleaned properly.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045182	A. Building B. Wing	08/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Courtyard Rehabilitation and Health Center, LLC	2415 W Hillsboro El Dorado, AR 71730

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 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. 48977 Based on observations, interviews, and facility policy review, the facility failed to ensure medications and/or biologicals were securely locked away. The findings include: On 08/26/24 at 6:05 PM, the Surveyor observed an unattended and unlocked cart with medications and cleaning solution used for treatments. On 08/28/24 at 6:21 PM, Licensed Practical Nurse #3 stated the cart should be locked. On 08/29/24 at 8:34 AM, the Director of Nursing (DON) stated she left the treatment cart unlocked and the cart should not have been unlocked. The DON stated a resident could have gotten in the treatment cart and got stuff out of there that could have been potentially harmful. A policy titled Pharmaceutical Services Policy noted Storage of drugs. All drugs and biologicals are stored in locked compartment under proper temperature controls.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045182	A. Building B. Wing	08/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Courtyard Rehabilitation and Health Center, LLC	2415 W Hillsboro El Dorado, AR 71730

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	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** 49596 Based on observation, interview, and record review, the facility failed to ensure food, including raw meat, was thawed, stored, and sealed properly to prevent a potential foodborne illness; to ensure expired food items were promptly removed from stock to reduce the risk of food-borne illness; to ensure prepared foods in the refrigerator were covered to prevent a potential foodborne illness; to ensure dietary staff washed their hands upon completion of a task and before starting another task; to ensure the meat slicer was cleaned after use; to ensure utensils placed in the clean utensil drawer and ready for use were clean and free of particles. These failed practices had the potential to affect 73 residents who received meals from 1 of 1 kitchen as documented on a list provided by the Administrator on [DATE]. The findings are: On [DATE] at 6:10 PM, during the initial tour of the kitchen the surveyor observed a plastic lock bag of raw chicken sitting on a shelf in the walk-in refrigerator that was not closed. The surveyor asked [NAME] #4 if the plastic lock k bag was closed securely. [NAME] #4 stated it was not sealed. The surveyor observed two boxes of thickened tea had expired on [DATE] sitting on a shelf in the walk-in refrigerator. One box had an open date of [DATE] and the second box had not been opened. The surveyor observed a stainless-steel container of white gravy sitting on a rack in the walk-in was not covered. [NAME] #4 stated the gravy was for breakfast the following morning and it should have been covered. On [DATE] at 6:20 PM, the surveyor observed a bag of frozen cookies and a bag of blueberry muffins not sealed in the walk-in freezer. [NAME] #4 sealed the cookies bag and placed the blueberry muffins in a plastic lock bag. On [DATE] at 6:40 PM, the surveyor asked [NAME] #4 who cleans the ice machine. [NAME] #4 stated any dietary staff could clean it. [NAME] #4 opened the ice machine and wiped the inside and the drop shield without washing hands or putting on a pair of gloves before performing the task. The surveyor asked [NAME] #4 what she should have done prior to getting into the ice machine. [NAME] #4 stated that she should have washed her hands. A review of the facility policy: Food and Nutrition Services, undated, showed Item IV Personal Hygiene - 1. Directs staff to wash hands carefully with soap and water .after handling . dirty dishes. The policy was given to the Survey Team, by the Nurse Consultant on [DATE] at 12:55 PM. A review of facility policy: Handwashing and Glove Usage in Food Service: undated showed Introduction: According to the Center for Disease Control and Prevention (DDC) hand washing is the single most important way to stop the spread of infection. Correct hand washing procedure must be continually monitored by Food Service managers. The policy also indicates when food handlers must wash their hands; Bullet point 13 - After touching anything else such as dirty equipment, work surfaces or cloths. and gloves should be changed before beginning a different task. The policy was given to the Survey Team by the Administrator on [DATE] at 9:49 AM. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045182	A. Building B. Wing	08/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Courtyard Rehabilitation and Health Center, LLC	2415 W Hillsboro El Dorado, AR 71730

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 [DATE] at 6:50 PM, the surveyor observed a small piece of pinkish substance lying on a meat slicer. The surveyor asked [NAME] #4 if the meat slicer had been used during the evening meal. [NAME] #4 stated it was not used for the evening meal but had been used to slicing ham at lunch. The surveyor asked [NAME] #4 what the pinkish substance was. [NAME] #4 thought it looked like ham. A review of the policy: Food and Nutrition Services, undated, showed VI: Proper food handling, item S. All food grinders, choppers, mixers, etc. should be cleaned, sanitized, dried, and reassembled after each use. The policy was given to the Survey Team, by the Nurse Consultant on [DATE] at 12:55 PM. On [DATE] at 6:55 PM, the surveyor observed a white particle lying inside a ladle in the utensil drawer, ready for use. On [DATE] at 7:00 PM, the surveyor observed the dishwasher being loaded and noticed the temperature log sheet did not have any temps logged for the lunch or dinner meals. Dietary Aide (DA) #5 and [NAME] #6 were rinsing dishes and loading them into the dish racks. The surveyor asked how you know the dishes were being sanitized. [NAME] #6 said they check it by running a dish cycle then we check the temperature and the strip Part Per Million (PPM). Then we log it on the log. She said they had run the dishwasher, and it was 140 degrees, and the strip was green. The surveyor asked DA#5 and [NAME] #6 to check the PPM on the dishwasher. [NAME] #6 proceeded to run the machine and placed the strip in the water holding in the bottom of the dishwasher. The strip did not change colors. [NAME] #6 checked two strips from the bottle sitting on top of the top of the dishwasher and then retrieved a third strip from a bottle in the manager's office. All 3 strips remained white. The Administrator was notified, and informed the surveyor that he would contact the facility chemical representative to be at the facility the next morning. The Administrator informed the surveyor the dishwasher would not be used until the problem was resolved and the staff would use the three compartments sink to wash the dishes. On [DATE] at 7:23 AM, the chemical representative was at the facility to work on the dishwasher. The chemical representative showed the surveyor the problem. The sanitizer hose was not placed in the sanitizer bucket correctly. He informed the surveyor that this was a low-temp machine and the temp had to be at 120 degrees with the sanitizer to sanitize the dishes. On [DATE] at 6:11 AM, the surveyor observed food had been placed on the steam table at 6:15 AM. The food on the steam table was not covered until 6:44 AM. The surveyor interviewed staff DA#7 and asked why it is important to cover food on the steam table. DA#7 stated, to keep flies off. On [DATE] at 6:30 AM, the surveyor observed two rolls of frozen ground beef sitting on a rolling cart in the kitchen. At 6:53 AM, [NAME] #8 placed the two rolls of ground beef in a sink and turned on the water and left the water running over the meat. At 7:00 AM, the surveyor observed the water that had been running over the two rolls of ground beef had been turned off. At 7:22 AM, DA #7 is observed turning the water on and leaving it running over the ground beef. The meat appeared to be frozen. A review of policy Food and Nutrition Services undated showed section V item F:Frozen foods must be thawed at refrigeration temperatures of 40 degrees or below or quick-thawed as part of the cooking process. The policy was given to the Survey Team, by the Nurse Consultant on [DATE] at 12:55 PM. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045182	A. Building B. Wing	08/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Courtyard Rehabilitation and Health Center, LLC	2415 W Hillsboro El Dorado, AR 71730

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 [DATE] at 7:07 AM, [NAME] #9 was observed holding the plate with her thumb on the food surface of the plates. [NAME] #9 positioned the plate on the serving tray and then placed food on the food surface of the plate. [NAME] #9 picked up two more plates in this manner. The surveyor brought this to the attention of [NAME] #8. At 7:13 AM, [NAME] #9 was observed picking up a divided plate by putting three fingers in one of the divided slots on the food surface of the plate and grasping the plate. A review of policy, Food and Nutrition Services, undated, showed VI Proper Food Handling, item N. Utensils cups, glasses and dishes must be handled in such a way as to avoid touching surfaces with which food or drink will come in contact . The policy was given to the Survey Team, by the Nurse Consultant on [DATE] at 12:55 PM. On [DATE] at 10:38 AM, Surveyor observed [NAME] #9 prepare pureed spaghetti with meat sauce. Upon [NAME] #9 completing the process, the surveyor observed the pureed spaghetti with meat sauce and noted it was gritty in appearance. The surveyor asked [NAME] #9 how the pureed spaghetti looked to her. [NAME] #9 poured the pureed spaghetti into a serving container and stated, It looks good. The surveyor then asked [NAME] #8 how the pureed spaghetti appeared to her. [NAME] #8 said it looks gritty and lumpy. [NAME] #8 instructed [NAME] #9 to puree the spaghetti again. [NAME] #9 pureed the spaghetti a second time and then poured it into the serving container. [NAME] #9 asked [NAME] #8 how it looked. [NAME] #8 told her to do it again and explained to [NAME] #9 that it had to be smooth like baby food. [NAME] #9 pureed the spaghetti a third time. On [DATE] at 10:50 AM, [NAME] #9 was observed going from preparing the pureed spaghetti to the storage drawer that contained clean tongs and other utensils. [NAME] #9 did not wash her hands between pureeing the spaghetti and putting her hand in the drawer of clean utensil drawer and retrieving a set of tongs.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045182	A. Building B. Wing	08/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Courtyard Rehabilitation and Health Center, LLC	2415 W Hillsboro El Dorado, AR 71730

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 48977 Based on observations, interviews, record reviews and facility policy review, the facility failed to ensure that staff used appropriate infection control measures and donned the proper Personal Protective Equipment (PPE) during high-contact care for 1 (Resident #8) sampled resident. The finding include: According to Quarterly Minimum Data Set with the Assessment Reference date of 8/12/2024, Resident #8 had severely impaired cognition. Resident #8 was incontinent of bowel and bladder and had a feeding tube. A Care Plan (revision date 06/19/2024) revealed Resident #8 required Enhanced Barrier Precautions (AEB) related to percutaneous endoscopic gastrostomy (PEG) tube. On 08/26/24 at 7:00 PM, the Surveyor observed Certified Nursing Assistant (CNA) #1 and #2 provide incontinence care to Resident #8. The Surveyor observed CNA #1 and #2 put on gloves but did not put on a gown to provide care. The Surveyor observed CNA #1 touch clean items and items commonly used by staff and/or the resident with gloved hands that had been used to wipe urine and feces. On 08/26/24 at 7:15 PM, CNA #2 stated Resident #8 had a PEG tube and was on BP. CNA #2 stated gown and gloves should be worn when care is provided to Resident #8. Both CNA #1 and #2 confirmed the bed control remote, clean wipes, clean brief, call light, and bed side table were touched with dirty gloved hands. On 08/29/24 at 08:43 AM, the Director of Nursing (DON) stated a resident with a PEG tube would be on BP and staff should don gown and gloves when providing high-contact care to prevent an immunocompromised resident from getting an infection from another resident. The DON confirmed if staff touched bed control remote, clean wipes, clean brief, call light, and bed side table were touched with dirty gloved hands it was an infection control issue. A policy titled Enhanced Barrier Precautions dated 2022 noted Enhanced barrier precautions refer to the use of gown and gloves for use during high-contact resident care activities for residents know to be colonized or infected with a [Multi-Drug Resistant Organism] MDRO as well as those at increased risk of MDRO acquisition (e.g., residents with wounds or indwelling medical devices). 4. High-contact resident care activities include: a. dressing b. bathing c. transferring d. providing hygiene e. changing linens f. changing brief or assisting with toileting g. device care or use: central lines, urinary catheter, feeding tubes, tracheostomy/ventilator tubes h. wound care: any skin opening requiring a dressing.