STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045187	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Green House Cottages of Wentworth Place	26 Warnock Springs Road Magnolia, AR 71753

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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 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. 50580 51381 42965 Based on interviews, record review, and facility policy review, it was determined the facility failed to notify and provide a copy of the written notice to the long-term care ombudsman when a resident was transferred to the hospital for 3 (Resident #88, #85, and # 212) of 3 sampled residents reviewed for hospitalization . The findings are: 1. Review of an annual Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 7/16/24 indicated Resident #88 had diagnoses of dementia, history of falling, personal history of healed traumatic fracture, muscle weakness. The MDS indicated Resident #88 had a Brief Interview for Mental Status (BIMS) score of 4 (0-7 suggests severe cognitive impairment). a. A Progress Note for 8/23/2024 at 09:38 AM read, This nurse called and notified elder's daughter of elder's condition. Daughter stated that she was not feeling well herself and that she was afraid she had got [Resident #88] sick. The Daughter was notified of [Resident #88] being sent out to (Name of Hospital) for further evaluation . b. On 9/18/24 at 10:00 AM, the surveyor examined Emergency Transfers from Facility log for the month of August, noting Resident # 88 was not on the list. c. On 9/18/24 at 12:05 PM, the surveyor requested notice of ombudsman notification for resident Hospital transfers for Resident # 88 and Resident # 85. d. On 09/18/24 at 2:29 PM, the surveyor received a revised Emergency Transfers from Facility log from the Social Services Director confirming the Ombudsman was notified 9/18/24 of Resident # 88's and Resident #85's hospitalization in August. 2. Review of the quarterly MDS with an ARD of 08/19/24 indicated Resident #85 had diagnoses of chronic obstructive pulmonary disease, stroke, and repeated falls, and scored 3 (0-7 indicates severe impairment) on the BIMS. (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: 045187	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/19/2024

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	a. An Advanced Practice Registered Nurse (APRN) progress note dated 6/30/2024 indicated Resident #85 had been found on the floor by staff and the resident reported hitting their head and experiencing neck pain. Following the assessment, the APRN ordered the resident be sent to the ER (emergency room) for hitting their head post fall and abnormal vital signs. b. A History and Physical dated 06/30/2024 contained in the After Visit Summary report from (name of hospital) indicated Resident #85 was admitted to the hospital on 6/30/2024 with diagnoses of subarachnoid bleed after a fall where the resident hit their head and pneumonia. c. A review of the Emergency Transfer from Facility log and the Admission/Transfer to/from Report for both June 2024 and July 2024, provided by the Social Services Director at 8:50 AM on 9/18/2024 to confirm notification to the Ombudsman, did not show Resident #85's name. d. On 09/18/24 at 03:06 PM, the surveyor interviewed the Administrator and the Social Services Director regarding the Ombudsman not being notified of resident transfer to hospital for Resident # 88 in August 2024 and Resident # 85 in June 2024. Both staff stated it was overlooked, Ombudsman was notified on 9/18/2024. 3. Review of the admission MDS with an ARD of 7/27/24 indicated Resident #212 had a diagnoses of end stage renal disease, diabetes mellitus, and sleep apnea, and scored 12 (13-15 indicates cognitively intact) on the BIMS. a. Review of the Notice of Transfer/Discharge/LOA (Leave of Absence) with Bed Hold Policy form indicated Resident #212 was transferred to (Name of Hospital) for a change of condition on 8/21/24. b. Review of the Summary of Care report dated 9/10/24 from (Name of Hospital) indicated Resident #212 was admitted to the hospital from 8/21/24 to 9/10/24 with diagnoses of acute renal failure with acute tubular necrosis superimposed on chronic renal failure, sepsis and diabetes mellitus. c. Reviewed the forms titled Emergency Transfers from facility dated August 2024 and the Admissions/Discharge To/From Report for 8/1/2024 to 8/31/2024 provided by the Social Director on 9/18/2024 at 8:50 AM that documented the notification to the Ombudsman of residents that were transferred to the hospital in August of 2024 and neither of the forms included Resident #212 name. d. On 09/18/24 at 4:35 PM, the surveyor informed the Social Director and the Administrator Residents 212's name was not found after reviewing the lists provided by the facility showing notification of the Ombudsman of transfers to hospital during August. The Social Director stated the resident was not on the list because the resident was placed on bed hold and the list generated for the Ombudsman did not include bed holds. The Social Director stated they had come up with a process to ensure the monthly list sent to the Ombudsman included all resident transfers. e. On 09/19/2024 at 9:28 AM, the policy titled, Transfer and Discharge (undated) provided by the Administrator indicated before a resident is discharged the facility will notify the resident, a family member, or legal representative, and send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman.

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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** 47916 Based on observation, interview, and facility policy review, the facility failed to ensure the lift pad was free of fraying and holes for 1 (Resident #54) sampled resident reviewed for accidents and injuries, and to ensure a resident was not allowed to smoke outside without supervision affecting 1 (Resident #59) sampled resident of 2 Sampled (Resident #24, #59) residents reviewed for smoking. Findings include: 1. A review of Medical Diagnoses, revealed Resident #54 with a diagnoses of Huntington's disease, stroke, and major depressive disorders. a. The annual Minimum Data Set (MDS) with an Assessment Reference Date (ARDs) of 01/22/2024 indicated a Brief Interview for Mental Status (BIMs) score of 03 (0-7 suggest severely impaired). Section GG0130 indicated Resident #54 is totally dependent on staff for meals, transfers, dressing, toileting, and personal hygiene. b. A review of Resident #54's Care Plan, revised on 07/18/2024, revealed that Resident #54 is totally dependent on staff and requires a lift with two-person assistance for transfers. c. A review of an in-service dated 08/09/2024 revealed staff were educated in lift pad sizing and inspecting lift pads before use. d. On 09/16/2024 at 11:12 AM, Resident #54 was observed resting quietly in a geriatric chair in the common area at [NAME] House, on a purple lift pad with red trim with a small hole near the left of Resident #54's head, and three small areas of fraying around the trim near the head, and 2 frayed areas near the right arm. e. On 09/17/2024 at 01:55 PM, a purple lift pad with red trim was observed hanging on Resident #54's bathroom door. Shahbaz #7 and Shahbaz #8 were asked when a lift pad would be removed from service. They were not sure why a lift pad would not be used, or how to remove one from service. Shahbaz #8 picked up the purple lift pad with red trim and both examined it. Shahbaz #7 identified 3 burn holes, a small hole at the top of the lift pad, and a nickel size hole near the bottom nylon straps, and 2-3 areas of fraying around the edges of the lift pad. Shahbaz #7 confirmed they borrowed this lift pad from another cottage and was using it on Resident #54. Shahbaz #8 confirmed that the lift pad could rip while lifting a resident and cause an accident. f. During an interview with the Director of Nursing (DON) on 09/18/2024 at 03:45 PM, the DON was asked the process staff are expected to follow to remove lift pads from service. DON stated that if a lift pad is frayed, or has holes the Shahbaz can throw them away, and are expected to tell the charge nurse so that new lift pads can be ordered. Lift pads with holes and fraying would not be considered safe and could cause resident accidents. 2. Review of the Medical Diagnoses revealed Resident #59 had diagnoses of chronic obstructive pulmonary disease (COPD), obstructive sleep apnea, and left foot contracture. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	a. Review of an in-service titled Smoking with or without Supervision and Apron requirements, revealed that all residents that smoke have a smoking assessment, and staff must be outside with a resident that requires supervision. b. A review of Resident #59's Care Plan, revised 09/20/2023, revealed Resident #59 has been educated on residents smoking evaluation and requires supervision of staff or a family member when smoking, and must wear a smoking apron. c. On 09/17/2024 at 12:47 PM, Resident #59 was observed sitting on the porch alone at [NAME] House smoking a cigar and had a second cigar resting on his/her chest. d. On 09/17/2024 at 1:00 PM, Shahbaz #9 came outside and assisted Resident #59 in lighting a second cigar, and then returned inside the cottage. e. On 09/17/2024 at 1:02 PM, Shahbaz #9 was followed inside the cottage and was observed looking in a drawer near the snacks, with her back to the front windows. The Surveyor asked Shahbaz #9 the process for smoking outside unsupervised and if Resident #59 had gone through that process. Shahbaz #9 stated that Resident #59 did not require supervision but was seated outside near the far-right corner window so he could be checked on. f. Review of the Smoking-Safety Screening dated 09/09/2024 revealed Resident #59 required supervision and a smoking apron while smoking. g. During an interview with the DON on 09/18/2024 at 03:40 PM, the DON was asked the facilities interpretation of supervised smoking, and if checking on someone from across the room and glancing out the window was considered supervision. The DON confirmed that a staff member should be outside with the resident while smoking to be supervision and confirmed watching out a window is not considered supervision, and a resident could burn themselves. h. On 09/18/2024 at 6:42 PM, a review of a policy titled Smoking, revealed the facilities policy is to ensure a safe environment for residents to smoke outside. All residents that want to smoke outside will be assessed to determine what the resident needs to be safe when smoking. The facility also provided page 2 of a document from the state agency confirming that a facility must assess a resident and describe the methods used to deem a resident safe to smoke unsupervised.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. 42965 Based on observation, interview, and record review, the facility failed to ensure there was a physician's order for oxygen therapy for 1(Resident #212) of 3 (Resident #59, #212 and #366) sampled residents that were reviewed for respiratory care. The findings are: 1. Review of the admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 7/27/2024 indicated Resident #212 had diagnoses of end stage renal disease, diabetes mellitus, and sleep apnea, and scored 12(13-15 indicates cognitively intact) on the Brief Interview for Mental Status). a Review of Resident #212's Order Summary Report for September 2024 did not show that the resident had an order for oxygen therapy. b. On 09/16/2024 at 12:13 PM, Resident #212 was sitting up in a recliner, eyes closed, with oxygen in use per nasal cannula at 1.5 liters. c. On 09/16/2024 at 02:44 PM, Resident #212 was sitting up in chair watching television, with oxygen in use at 1.5 liters per nasal cannula. The resident was unsure if they used oxygen continuously but knew it was always available. d. On 09/17/2024 at 03:20 PM, Resident #212 was lying in bed with oxygen in use at 1.5 liters per nasal cannula. e. On 09/18/20244 at 12:05 PM, Resident #212 was sitting in a wheelchair in their room with oxygen in use at 1.5 liters per nasal cannula. f. On 09/18/2024 at 12:08 PM, Registered Nurse (RN) #11 was asked to accompany the surveyor to Resident #212's room and asked to tell the Surveyor what the resident's oxygen flow rate was set at. RN #11 looked at the resident's oxygen and stated it looked like it was set at 1.5 (liters). RN #11 was asked what Resident #212's oxygen flow rate should be set on and after looking in the electronic record, RN#11 stated she did not see an oxygen order for the resident. RN#11 was asked if there should be a physician's order telling you what the oxygen flow rate should be if the resident is receiving oxygen, and stated there should be so that the resident gets the correct oxygen perfusion through their body based on their diagnosis. g. On 09/18/2024 at 01:50 PM, the Director of Nursing (DON) was asked if the use of oxygen require a physician's order and what the physicians order should include, and she stated there should be an order and it should include the flow rate and whether the oxygen is PRN (as needed) or continuous. The DON was asked if she was aware that Resident 212 was receiving oxygen without a physician's order, and she stated she was made aware by the resident's nurse earlier and they had obtained an order for the oxygen. The DON was asked why it was important that there is a physician's order for oxygen, and she stated there should be an order because oxygen is a medication. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	h. On 09/18/2024 at 2:50 PM, the Administrator came to the surveyor and stated that they did not have a policy on use of oxygen.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47916 Based on observation, record review, interview, and facility policy review, it was determined that the facility failed to ensure resident medications were stored behind a lock to prevent unauthorized staff or resident access. This failed practice had the potential to affect 1 (Resident #32) sampled resident. The findings are: 1. A review of a policy titled Medication Storage in the Facility, revised January 2018, revealed that medications should be stored behind locks, and be accessible to licensed and pharmacy personnel. Medication rooms and carts are to be locked up when not being attended by authorized personnel. 2. A review of Medical Diagnoses for Resident #32 revealed diagnoses of stroke, dementia, and diabetes mellitus. 3. On 09/17/2024 at 12:58 PM, the surveyor walked in Resident #32's room and the door to the bottom drug cabinet near the doorway fell open. The Surveyor pulled on the knob of the upper drug cabinet, and the door swung open easily revealing: a. Jardiance 25 mg (milligram) tablet, 1 tab b. Metformin 500 mg oral twice a day, 1 tab c. Vitamin D 1250 mg bottle d. Lantus 100u/ml (unit/milliliter), 10 ml vial e. Fiber lax 625 mg tables x 2 bottles f. Loratadine allergy relief 10 mg 1 bottle g. Acetaminophen 500 mg tablets, 2 bottles h. Fish oil 1000 mg bottle i. Glucosamine chondroitin advanced bottle j. Pen needles, 1 box k. Gabapentin 300 mg capsule at night, 1 tablet l. Atorvastatin 40 mg nightly, 1 tablet (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	m. Metoprolol 50 mg, 1 tablet n. Losartan 25 mg twice a day, 1 tablet o. Terazosin 2 mg oral, 1 capsule 4. During an interview at [NAME] House with Registered Nurse #10 (RN) on 09/17/2024 at 1:05 PM, RN #10 was asked about the process for storing medications in resident rooms. RN #10 stated that both medication cabinets in Resident #32's room are supposed to be locked to prevent residents from taking someone else's medications. 5. During an interview with the Director of Nursing (DON) on 09/18/2024 at 3:45 PM, the DON confirmed that staff are expected to make sure medications are kept behind locked doors to prevent residents from self-medicating and hurting themselves.

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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 prepared in a method that maintained nutritive value and taste that were acceptable to the residents to improve palatability and encourage good nutritional intake during 1 of 1 meal observed. The findings are: 1. A review of document titled, Quantified Recipe .Breaded Chicken On Bun, initiated for 3/20/2024 and provided by the Dietary Manager on 9/18/2024 at 12:14 PM, indicated for 5 residents placed 5 sandwiches use 1.75 cup plus 2 tablespoons of water or stock. a. On 9/17/24 at 4:09 PM, Dietary [NAME] (DC) #1 placed 5 servings of fried chicken breast into a blade, added 4 cups of hot water from the sink and stated they used 5 chicken breasts, and the same amount of water to help maintain the consistency, instead of 1.75 cup plus 2 tablespoon of water or stock. 2. A review of a document titled, Quantified Recipe .Vegetable Blend, initiated 3/20/2024 and provided by the Dietary Manager on 9/18/2024 at 12:14 PM, indicated for 5 residents use 5.5 cups of vegetable blend of choice and 1 tablespoon plus teaspoon of thickener and no water, a. On 09/17/24 at 4:31 PM, DC #1 used a 4-ounce spoon to place 5 servings of mixed vegetables into a blender, added 1.25 cups of tap water and 2 tablespoon of thickener and pureed, instead 1 tablespoon plus 2 teaspoons of thickener and no water. 3. A review of a document titled, Quantified Recipe .puree dinner roll, initiated 3/20/2024 and provided by the Dietary Manager on 9/18/2024 at 12:14 PM, indicated for 5 residents use dinner roll, 1 each, plus 0.75 teaspoon thickener and 2 tablespoons of water or milk. a. On 09/17/24 at 4:38 PM, DC #1 placed 6 slices of bread into a blender, added 1.25 cups of tap water, instead of 0.5 cup plus 2 tablespoon water or milk. 4. On 9/17/24 at 6:12 PM, DC #1 stated food pureed with water would taste bland.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 03508 Based on observations, interview, and facility policy review, 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 those residents who required pureed diets for 2 of 2 meals observed. The findings are: 1. On 9/17/24 at 5:17 PM, during observation of supper meal in [NAME] House, the following pureed food items were in a crock pot awaiting service: a. Pureed fried chicken breast. The consistency was chunky. There were pieces of chicken visible in the mixture. b. Pureed mixed vegetables. The consistency of the pureed was lumpy and not smooth. There were pieces of vegetables and stems visible in the mixture. c. Pureed tarter tots. The consistency was lumpy and not smooth. There were pieces of potatoes still in the mixture. 2. On 9/17/24 at 6:01 PM, the Dietary Manager stated the consistency pureed fried chicken breast was chunky, there were still pieces of chicken in the mixture. It is supposed to be pudding consistency. Pureed mixed vegetables has pieces of vegetables and vegetables stems in it and for the pureed tartar tots they were pieces of potato in it. They should have been pureed longer. 3. On 9/17/24 at 6:03 PM, Shahbaz #6 stated the consistency of the pureed fried chicken breast was chunky. Pureed vegetables have stems and lumps in it and pureed tarter tots was lumpy. 4. On 9/17/24 at 6:05 PM, Shahbaz #5 who prepared the supper meal stated the consistency of the pureed chicken was chunky, pureed mixed vegetables has lumps and vegetable stems sticking out. 5. On 9/18/24 at 9:13 AM, during observation of the breakfast meal in [NAME] House the pureed food items served to the residents who required pureed diets were not properly pureed: a. Pureed bread was runny and there were pieces of bread visible in the mixture. b. Pureed sausage had more of a mechanical texture. (Mechanical soft texture foods can be pureed, finely chopped, blended, or ground to make them smaller, softer, and easier to chew. It differs from a pureed diet, which includes foods that require no chewing.) 6. On 9/18/24 at 9:14 AM, the Dietary Manager stated the pureed bread was lumpy and runny, she can see particles of bread and pureed sausage is mechanically like. 7. On 9/18/24 at 9:14 AM, Shahbaz #5 stated the pureed bread has particles of bread in it, and the pureed sausage is mechanically soft and not pureed. (continued on next page)

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	8. On 9/18/24 at 9:15 AM, Shahbaz #6 who prepared breakfast meal stated pureed bread had particles of bread in it and pureed sausage is mechanical like. I should have added more liquid to it. 9. The pureed fried chicken, pureed tarter tots, and pureed mixed vegetables remained as thick and lumpy as they were when first observed in the crock pot. This consistency persisted when they were served to the residents. 10. A review of a facility policy titled, In-service: Puree Foods, not dated, and provided by the Dietary Manager on 9/18/2024, indicated pureed food should be the consistency of pudding or mashed potatoes.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 03508 Based on observation, interview, and facility policy review, the facility failed to ensure dietary staff and Shahbaz thoroughly washed their hands and changed gloves when contaminated and before handling food and clean equipment to decrease the potential for food borne illness for residents receiving meals from 2(Pavilion House and [NAME] House) kitchens; expired food items and spices were promptly removed/discarded on or before the expiration or use by date to minimize the potential for food borne illness for residents who received meals from 4 A(Pavilion House, [NAME] House, [NAME] House and [NAME] House) kitchens; hot food items were maintained at the required temperatures on the mini crock pots to prevent potential food borne illness for residents who received meals from 1(Brown House) kitchen. These failed practices had the potential to affect residents who received meals from the kitchen (with a total census of), according to the list provided by the Dietary Manager. The findings are. Pavilion House: 1. On [DATE] at 4:01 AM, the following observations were made in the kitchen during supper meal preparation: 2. Dietary [NAME] (DC)#1 wore mittens on her hands when she removed a pan of chicken from the oven and placed it on the counter. Without washing her hands, she picked up a clean blade and attached it to the base of the blender to be used in pureeing food items to be served to the residents on pureed diets. 3. On [DATE] at 4:19 PM, DC #1 turned on the 3-compartment sink faucet and washed the blender bowl, blade and the lid with hot water but didn't use soap. Without sanitizing it, she attached the blender bowl to the motor and attached a blade at the base of the blender. As DC #1 was about to use it to puree food items to be served to the residents on pureed diets for supper, DC #1 was asked if food processors should be washed with soap and sanitized before been used. DC #1 stated, Yes. 4. On [DATE] at 4:22 PM, Dietary Aide (DA) #2 removed cartons of thickened liquids from the storage and placed them on the counter. DA #2 pushed a cart that contained glasses towards the counter, contaminating her hands. Without washing her hands, she picked up glasses by their rims and poured beverages in them to serve the residents for supper. 5. On [DATE] at 10:09 AM, the following observations were made on a shelf in the freezer located in the storage room: a. One container of cottage cheese with an expiration date of [DATE]. b. One container of potato salad with an expiration of [DATE]. [NAME] House (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045187	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Green House Cottages of Wentworth Place	26 Warnock Springs Road Magnolia, AR 71753

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 - Some	1. On [DATE] at 9:53 AM, one container of chili powder in the kitchen cabinet had expiration date of [DATE]. Brown House 1. On [DATE] at 4:55 PM, the temperatures of the food items when checked and read by Shahbaz #4 were: a. Ground fried chicken breast in a crock pot was 128 degrees Fahrenheit. b. The fried chicken breast was 130 degrees Fahrenheit. c. Mechanical tarter tots in a foil pan on the counter was 125 degrees Fahrenheit. [NAME] House. 1. On [DATE] at 8:47 AM, the following observations were made in the kitchen cabinet. a. One gallon of garlic powder with an expiration date of ,d+[DATE] 2023. b. One container of ground thyme with an expiration date of [DATE]. c. One container of Mediterranean style ground oregano with an expiration date of [DATE]. Brown House. 1. On [DATE] at 9:07 AM, one container of potato salad was on a shelf in the refrigerator with an expiration date of [DATE]. 2. On [DATE] at 9:09 AM, the following observations were made on a shelf in the storage room: a. One bag of hot buns with an expiration date of [DATE]. b. One bag of bread with an expiration date of [DATE]. A review of a facility policy titled, Handwashing and Glove Usage in Food service, not dated and provided by the Dietary Manager on [DATE], indicated, hands must be washed before starting work and when engaging in any activities that may contaminate hands.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045187	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/19/2024
NAME OF PROVIDER OR SUPPLIER The Green House Cottages of Wentworth Place		STREET ADDRESS, CITY, STATE, ZIP CODE 26 Warnock Springs Road Magnolia, AR 71753	

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47916 Based on observation, record review, and interview, it was determined that the facility failed to ensure oxygen/nebulizer tubing and masks where changed every week in a timely manner to prevent respiratory infections affecting 1(Resident #59) of 3 sampled (Resident #59, #212, #366) residents reviewed for respiratory. Findings include: 1. A review of the Medical Diagnoses, revealed Resident #59 had diagnoses of chronic obstructive pulmonary disease (COPD), obstructive sleep apnea, and left foot contracture. a. A review of the Physicians Order, dated 06/29/2023, revealed Resident #59 gets albuterol updrafts three times a day. b. A review of Resident #59's Care Plan, revised on 07/21/2024, revealed Resident #59 has COPD and obstructive sleep apnea and to give medications as ordered. c. On 09/16/2024 at 10:24 AM, a storage bag and nebulizer mask on Resident #59's bedside table was dated 09/05/2024. d. On 09/17/2024 at 10:15 PM, a stored nebulizer mask with 09/5/2024 written on the side was stored on the right bedside table. e. A review of Resident #59's Medication Administration Record, dated September 2004 on 09/18/2024 at 08:51 AM, revealed that Resident #59 is compliant with nebulizer treatments three times a day. f. On 09/18/2024 at 09:46 AM, Resident #59 gave permission to open his/her bedside drawer to look at Resident #59's nebulizer tubing and mask was dated 09/05/2024. g. During an interview at [NAME] House with Licensed Practical Nurse #12 (LPN) on 09/18/2024 at 10:14 AM, LPN #12 was asked the process for changing oxygen tubing and nebulizer mask, and what process staff follows if they find oxygen tubing or nebulizer masks that have not been changed out. LPN #12 confirmed that night shift nurses change out oxygen tubing and nebulizer masks on Wednesday nights, but staff should notify a nurse on duty if they see tubing or nebulizer mask that are dated past one week. h. On 09/18/2024 at 10:17 AM, LPN #12 accompanied Surveyor to Resident #59's room and confirmed the oxygen mask and tubing were last changed on 9/05/2024, and they should have been changed after 7 days for sanitary reasons, and to prevent infection. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	i. During an interview with the Director of Nursing (DON) on 09/18/2024 at 03:35 PM, DON was asked what the process was for changing tubing and nebulizer mask. DON stated that nursing is expected to change out oxygen tubing and nebulizer mask every Wednesday night. DON confirmed that if staff finds tubing or nebulizer masks that were not changed out, they are expected to notify a nurse and confirmed that tubing and nebulizer mask dated 09/05/2024 should have already been changed out for cleanliness, and to prevent respiratory infections. The DON revealed that they do not have a policy addressing changing out oxygen tubing and nebulizer mask, but it is expected to be done every 7 days. j. On 09/19/2024 at 09:31 AM, Social Services Director (SSD) provided a letter from the administrator stating the facility does not have a policy or procedure for oxygen tube use.