

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  045209	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  06/12/2024
NAME OF PROVIDER OR SUPPLIER  The Crossing at Riverside Health and Rehabilitatio		STREET ADDRESS, CITY, STATE, ZIP CODE 2500 East Moore Avenue Searcy, AR 72143	

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)
<p>F 0693</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube.</p> <p>49596</p> <p>Based on observations, interviews, record reviews, and facility policy, the facility failed to provide appropriate treatment and services to prevent complications from enteral feedings for 1 (Resident #42) of 1 resident who was observed lying flat in bed when receiving a tube feeding.</p> <p>The findings are:</p> <p>On 06/10/2024 at 3:07 PM, the surveyor observed Resident #42 lying flat on their back in bed. The surveyor asked Licensed Practical Nurse (LPN) #8 to step into the room. LPN #8 stepped into the room and immediately gasped and immediately adjusted the head of bed (HOB) to 30 to 45 degrees.</p> <p>On 06/10/2024 at 3:08 PM, the surveyor conducted an interview with LPN #8. The surveyor asked LPN #8 what was the first thing you noticed about Resident #42 when you walked into the room. LPN 8 stated the head of the resident's bed was not elevated 30 to 40 degrees as it should be at all times. It was elevated earlier when I was in here, so the aides must have put [Resident #42] down to change them and did not elevate the HOB afterward. The surveyor asked why is that important. LPN #8 stated, so, she doesn't aspirate. She is on a continuous tube feeding. The surveyor asked, what is the tube feeding running at right now. LPN #8 stated, it is running at 35 milliliters per hour and 90 milliliter flush every 2 hours continuous.</p> <p>A review of Resident #42's Medication Administration Record (MAR) for 06/01/2024 to 06/30/2024 reflected Resident #42 was to receive an enteral feeding every day and night shift, with the HOB elevated 30 to 45 degrees at all times during feeding and for 1 Hour after feeding cessation. Order Date 09/25/2023.</p> <p>The surveyor reviewed the facility policy regarding Enteral Feedings-Safety Precautions, presented by the Administrator on 06/11/2024 at 9:30 AM. The policy stated, .Preventing Aspiration .Elevate the head of the bed (HOB) at least 30 [degrees] during tube feeding and at least 1 hour after feeding .</p>

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
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<p>F 0803</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident.</p> <p>03508</p> <p>Based on observation, record review, and interview, the facility failed to ensure meals were prepared and served according to the planned written menu to meet the nutritional needs of the residents for 1 of 1 meal observed. This failed practice had the potential to affect 8 residents who received enhanced foods in the dining room on the 100 Hall, 6 residents who received meal trays in the dining room on the 200 Hall, 13 residents who received meal trays in the dining room on the 300 Hall, and 5 residents who received meal trays in the dining room on the 400 Hall, as documented on a list provided by the Dietary Manager 06/10/2024 at 12:08 PM. The findings are:</p> <ol style="list-style-type: none"> <li>1. The menu for breakfast on 06/10/2024 documented the residents on enhanced food diets were to receive one cup of Super Cereal.</li> <li>2. On 06/10/2024 at 07:40 AM, Dietary Aide (DA) #3 used a #8 scoop to serve a single portion of fortified oatmeal to the residents on fortified diets from the kitchenette on the 300 Hall. At 08:03 AM, the Surveyor asked DA #3 what scoop size she used to serve the fortified oatmeal and how many servings she gave to each resident. DA #3 stated, I used the gray scoop #8 (1/2 cup) and gave one serving each.</li> <li>3. On 06/10/2024 at 07:46 AM, DA #4 used a #8 scoop to serve a single portion of fortified oatmeal to the residents on fortified diets from the kitchenette on the 400 Hall. At 08:00 AM, the Surveyor asked DA #4 what scoop size she used to serve the fortified oatmeal and how many servings she gave to each resident. DA #4 stated, I used the gray scoop #8 (1/2 cup) and gave one serving each.</li> <li>4. On 06/10/2024 at 08:08 AM, DA #6 used a #8 scoop to serve a single portion of super cereal to the residents on enhanced food. At 08:09 AM, the Surveyor asked DA #6, who served the breakfast meal on the 200 Hall, what scoop size did she used to serve the fortified oatmeal and how many servings she gave to each resident. DA #6 stated, I used the gray scoop #8 (1/2 cup) and gave one serving each.</li> </ol>		

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<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>03508</p> <p>Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature.</p> <p>Based on observation, record review and interview, the facility failed to ensure meals were served in a method that maintained the appearance of cold products and at temperatures that were acceptable to the residents to improve palatability and encourage good nutritional intake during 1 of 1 meal observed. This failed practice had the potential to affect 8 residents who received meal trays in their rooms on the 100 Hall, 6 residents who received meal trays in their room on the 200 Hall, 13 residents who received meal trays on the 300 Hall, and 5 residents who received meal trays in their room on the 400 Hall, as documented on a list provided by Dietary Manager on 06/10/2024 at 12:09 PM. The findings are:</p> <ol style="list-style-type: none"> <li>1. On 06/09/2024 at 10:40 AM, Resident #79 stated the food is never hot.</li> <li>2. On 06/09/2024 at 1:27 PM, Resident #323 was sitting up in bed eating lunch. Family members were present. During an interview, Resident #323 said the resident had been here a week, and this was the first warm meal the resident had had, and that breakfast is always cold. Resident #323 also said, but this morning it was so cold the resident could not eat it at all. Resident #323 also said, the resident and the resident's family have complained about it to staff, and they (staff) informed them it's always cold when we get to the end of the hall. Resident #323 further said the resident's family member asked them if they could start at this end of the hall every other day and they stated no because then all the others will start complaining on the other end.</li> <li>3. On 06/10/2024 at 7:52 AM, an unheated plate that contained a breakfast meal was on the counter by the steam table on the 400 hall dining room kitchenette. At 07:54 AM, as Nurse Aide #5 was about to deliver the tray to the room, the Surveyor asked Dietary Aide (DA) #3 to check the temperature of the food items. DA #3 did, and the temperatures were as follows:             <ol style="list-style-type: none"> <li>a. Scrambled eggs - 105 degrees Fahrenheit.</li> <li>b. Sausage links - 111.5 degrees Fahrenheit.</li> </ol> </li> <li>4. On 06/10/2024 at 12:43 AM, the Surveyor asked DA #3 to check the temperatures of food items on the last room tray on the counter by the steam table on the 300 hall dining room kitchenette. DA #3 did and the temperatures were as follows:             <ol style="list-style-type: none"> <li>a. Boneless chicken breast - 106.5 degrees Fahrenheit.</li> </ol> </li> </ol>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 03508</p> <p>Based on observation and interview, the facility failed to ensure manufacturer instructions on food labels was followed; foods stored in the refrigerator was covered and sealed to minimize the potential for food borne illness for residents who received meals from 1 of 1 kitchen; expired food items were promptly removed from stock to prevent potential food borne illness for residents who received meal trays from 1 of 1 kitchen; foods were dated the day received or opened to assure first in, first out usage to prevent potential for food bone illness; and dietary staff washed their hands before handling clean equipment or food items to prevent potential food borne illness for residents who received meals from 1 of 1 kitchen. These failed practices had the potential to affect 113 residents who received meals from the kitchen, (total census:115), as documented on a list provided by the Dietary Manager on [DATE] at 12:09 PM.</p> <p>The findings are:</p> <ol style="list-style-type: none"> <li>1. On [DATE] at 10:01 AM, the following observations were made in the kitchen area: <ul style="list-style-type: none"> <li>a. An opened bag of light brown sugar was on a shelf above the food preparation area. The bag was not sealed. There was no received or opened date on the bag.</li> <li>b. An opened bag of bread was on the counter. The bag was not sealed.</li> </ul> </li> <li>2. On [DATE] at 10:14 AM, Dietary Aide (DA) #1 picked up the water hose with his bare hand, used it to spray leftover food from inside of the dishes, contaminating his hands. He placed the dirty dishes in the dirty racks and pushed the racks into the dish washing machine to wash. DA #1 used a scraper to scrape off water on top of the utility cart. After the dishes stopped washing, he moved to the clean side of the dishwasher area and picked up clean dishes and placed them on the clean rack to be used in serving noon meal to the residents. The Surveyor asked DA #1 immediately what he should have done after touching dirty objects or before handling clean equipment. He stated, I should have washed my hands.</li> <li>3. On [DATE] at 10:21 AM, an opened bag of cocoa was on a rack in the storage room and was not sealed.</li> <li>4. On [DATE] at 10:27 AM, the following opened beverage containers were on top of the utility cart in the walk-in refrigerator. Their spouts were not covered, exposing them to cross contamination. <ul style="list-style-type: none"> <li>a. Two pitchers of apple juice.</li> <li>b. A pitcher of cranberry juice.</li> <li>c. Two pitchers of orange juice.</li> <li>d. A pitcher of grape juice.</li> </ul> </li> </ol> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>5. on [DATE] at 10:28 AM, the following observations were made in the walk-in freezer:</p> <p>a. An opened box of cookies. The box was not covered or sealed.</p> <p>b. An opened box of cheesy bread sticks.</p> <p>6. On [DATE] at 10:46 AM, an opened gallon of soy was on a shelf below the food preparation counter. The manufacturer specification on the gallon documented, Refrigerate after opening.</p> <p>7. On [DATE] at 10:58 AM, an opened package of frozen waffles was on a shelf in the freezer in the dining room on the 300 Hall. The box was not covered, and the bag was not sealed.</p> <p>8. On [DATE] at 11:08 AM, the following observations were made in the refrigerator on the 200 Hall:</p> <p>a. An opened resealable plastic bag that contained slices of lemon was on a shelf in the refrigerator. The bag was not sealed.</p> <p>b. A container of butter was on a shelf with an expiration date of [DATE].</p> <p>c. A container of cottage cheese was on a shelf in the refrigerator with an expiration date of [DATE].</p> <p>9. On [DATE] at 12:11 PM, DA #2 wore gloves while untying the bread bag, then proceeded to place slices of bread on the pan without changing gloves and washing her hands. She added slices of cheese from the bag onto each slice of bread to prepare grilled cheese sandwiches for the residents who requested grill cheese sandwich with their noon meal. At 12:17 PM, the Surveyor asked DA #2, What should you have done after touching dirty objects and before handling food items and cleaning equipment? She stated, I should have changed gloves and washed my hands.</p> <p>10. A facility policy titled, Preventing Foodborne Illness-Employee Hygiene and Sanitary Practices documented under employee must wash their hands.6. Employees must wash their hands: .c. Whenever entering or re-entering the kitchen. d. Before coming in contact with any food surfaces.h. After engaging in other activities that contaminate the hands .</p>		