STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045214	A. Building B. Wing	12/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hudson Memorial Nursing Home	700 N. College Avenue 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 0569 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify each resident of certain balances and convey resident funds upon discharge, eviction, or death. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48390 Based on interview, record review, and policy review, the facility failed to convey a resident's personal funds, to the individual or representative administering the individual's estate, within 30 days, for 1(Resident #163) sampled resident for whom the facility-maintained trust accounts, per a list provided by the Bookkeeper on [DATE] at 9:42 AM. The findings are: 1. On [DATE] at 9:42 AM, the Bookkeeper provided a document titled [Facility name] [Skilled Nursing Facility] SNF Trust Current Account Balance as of [DATE], which was reviewed and indicated a trust account for Resident #163 contained a closing balance of $1,237.24. 2. On [DATE] at 10:00 AM, review of the Record of Death indicated Resident #163 passed away on [DATE]. 3. On [DATE] at 12:00 PM, the Bookkeeper was interviewed with concurrent observations and stated the facility had four (4) days to return a resident's money from a trust account when a resident discharges or expires. The Bookkeeper stated Resident #163 expired on [DATE]. 4. On [DATE] at 12:07 PM, a review of a document titled Trust Transaction History for Resident #163 revealed interest had been paid each month and the balance as of [DATE] was $1,237.24. 5. On [DATE] at 12:29 PM, the Bookkeeper provided an undated policy titled Protection of Resident Funds Policy. The policy was reviewed and indicated upon the death of a resident who has personal funds, the facility will ensure, within 30 days, the resident ' s funds will be conveyed to the individual or probate jurisdiction administering the resident ' s estate or try to locate the responsible party or heir to the estate. 6. During the exit conference on [DATE], the Administrator stated Resident #163's stepdaughter did not want the resident's funds returned to her and the resident had no other person to contact. The Administrator was interviewed and stated she did not reach out to her governing body or the proper state authority for guidance regarding how to handle Resident #163's remaining funds.

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
	045214	A. Building B. Wing	12/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hudson Memorial Nursing Home	700 N. College Avenue 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 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. 37925 Based on record review, interview, and facility document review, the facility failed to coordinate with the proper state agency to ensure a Level 2 (II) pre-admission screening and resident review (PASRR) evaluation report was obtained to determine if a resident required further services for 1 (Resident #15) sampled resident reviewed for a Level II PASRR. The findings are: On 12/17/2024 at 10:00 AM, Resident #15's electronic health record was reviewed and there was no Level II PASRR evaluation report in the resident's record. On 12/17/2024, the Administrator was asked to provide documentation for a Level II PASRR screening for this resident. At 3:26 PM, the Director of Nursing (DON) provided a document titled [outside agency name], dated 02/13/24 [02/13/2024], and indicated the resident could not be admitted until a Level II PASRR was completed. A document titled [outside agency name], dated 02/25/2014, was reviewed and indicated the resident had been approved for nursing home placement of choice. The document indicated the nursing facility must contact the outside agency and provide the resident's admitted to receive the completed PASRR evaluation. Resident #15's Order Summary Report was reviewed and indicated the resident had diagnoses of a nerve disorder caused by damage or abnormal development in the brain which affects movement and posture (cerebral palsy). A quarterly Minimum Data Set with an Assessment Reference Date of 10/23/2024 was reviewed and indicated Resident #15 had a Brief Interview for Mental Status score of 14, indicating cognitively intact, and had other behavioral symptoms, not directed towards others, such as hitting, scratching or verbal/vocal symptoms like screaming. On 12/17/2024, a review of the care plan dated 12/06/2024 indicated the resident had a communication problem related to cerebral palsy and intellectual disabilities and to engage resident in simple, structured activities that avoid overly demanding tasks. There was no PASRR information on the care plan. On 12/19/2024 at 8:40 AM, the Administrator stated she was unable to locate the Level II PASSR evaluation for Resident #15. This surveyor entered the Administrator's office later in the day to request other information and the Administrator stated she had located information from another state agency regarding Resident #15 and PASRR information. She had documents in her hand and stated there was no recommendations listed on the form. This surveyor asked if she was providing documentation for the Level II PASRR, she stated she was not and did not provide the documents to this surveyor for review. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045214	A. Building B. Wing	12/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hudson Memorial Nursing Home	700 N. College Avenue 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 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/19/2024 at 12:46 PM, the DON provided a document which he stated the facility used as a guide regarding Level II PASRR screening. An undated document titled Who needs a PASRR [Level II) Screening ?????? was reviewed and indicated clients with a developmental disability, such as cerebral palsy, required a Level II PASRR. The document indicated a PASRR evaluation process, which indicated if the client is eligible for admission, the client would enter the nursing facility NF) and the NF would call the outside agency with the admitted and the outside agency would mail the Level II assessment to the NF or guardian.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045214	A. Building B. Wing	12/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hudson Memorial Nursing Home	700 N. College Avenue 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 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. 37925 Based on observation, interview, record review, and facility policy review, the facility failed to ensure a resident was offered individual activities on a consistent basis for 1 (Resident #35) of 2 (Residents #28 and #35) sampled residents reviewed for activities. The findings are: On 12/16/2024 at 12:07 PM, Resident #35 was lying in bed with eyes closed. The resident 's eyes opened to verbal stimuli. The television (tv) was off at this time. Resident #35's Order Summary Report was reviewed and indicated diagnoses of depression and anxiety and indicated the resident needed continued care in a nursing home due to inability to live independently and the need for medication assistance, observation, and planning. A quarterly Minimum Data Set with an Assessment Reference Date of 12/13/2024, was reviewed and indicated Resident #35 had a Brief Interview for Mental Status score of 7, which indicated severely cognitively impaired. Resident #35's care plan, dated 12/16/2024, was reviewed and indicated the resident was dependent on staff for meeting emotional, intellectual, physical, and social needs related to an inability to move (immobility), physical limitations, and anxiety. Interventions were to invite the resident to scheduled activities and the resident needs one-to-one (1:1) bedside/in-room visits and activities if unable to attend out of room events. On 12/18/2024 at 10:42 AM, Resident #35 was lying supine in bed with eyes closed. There was a 10:30 AM activity in the dining area at this time. The tv was not currently on. On 12/18/2024 2:36 PM, residents were in the dining room playing bingo and Resident #35 was not in attendance. At 2:50 PM, the resident was lying in bed awake. The tv was not on currently. On 12/19/2024 at 9:53 AM, the Activity Director (AD) and Activities Assistant (AA) were interviewed. This surveyor asked the AD if she did one-on-one activities with the residents and she stated they, she and the AA, had not been doing the one-on-one activities. She stated the AA had occasionally been doing them. The AD was asked to clarify occasionally and the AA stated, I usually go by two times a week. I go in and [Resident #35's] usually asleep. If I make a tour around again and [Resident #35]'s awake, I will [do an activity with the resident]. I'm not going to wake [the resident] up to do one [an activity]. This surveyor stated upon review of the resident's documentation in the computer, an activity was last indicated on 12/06/2024. The AD stated what was in the computer was what had been done. An Individual Activities and Room Visit Program policy, not dated, was reviewed and indicated individual activities would be provided for those residents whose situation or condition prevented participation in other types of activities. The policy indicated the activities offered were reflective of the resident's individual activity interests.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045214	A. Building B. Wing	12/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hudson Memorial Nursing Home	700 N. College Avenue 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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. 37925 Based on observation, record review, interview, and facility policy review, the facility failed to ensure the medication error rate was less than 5 percent (%) during the medication administration observation of 3 (Residents #11, #18, and #25) of 6 (Residents #11, #18, #20, #25, #35, and #54) sampled residents who received medications from 2 Licensed Practical Nurses (LPNs). 26 opportunities of medication administration were observed and 3 of the 26 medications were not administered in accordance with physician's orders, resulting in a medication error rate of 11.54%. The findings are: On 12/28/2024, LPN #4 was observed as she conducted the 8:00 AM medication pass to residents. At 8:26 AM, she obtained Resident #25's blood pressure (bp) using a manual blood pressure cuff and stated the bp was 131 over 52 (131/52). Once she gathered the medications, she entered the resident's room, administered the medications to the resident, but withheld the [medication name] (calcium channel blocker) 10 milligrams (mg) tablet. Resident #25's Order Summary Report was reviewed and indicated the resident had a diagnosis of high blood pressure (hypertension). The report indicated an order for [medication name] (calcium channel blocker) 10 mg give 1 tablet by mouth one time a day for high blood pressure. There were no parameters included on the physician's order indicating when to hold the medication. On 12/18/2024 at 8:47 AM, LPN #4 obtained Resident #18's blood pressure manually and indicated the bp was102 over 85 (102/85). At 8:58 AM, LPN #4 entered the resident's room and administered the medications to the resident but withheld the [medication name] (calcium channel blocker) 5 mg tablet. Resident #18's Order Summary Report was reviewed and indicated a diagnosis of hypertension. The report included a physician's order dated 01/03/2022 for [medication name] 5 mg give 1 tablet by mouth one time a day related to hypertension. There were no parameters included on the physician's order indicating when to hold the medication. On 12/18/2024 at 2:38 PM, LPN #4 was interviewed with concurrent observations. She was asked to review Resident #18's physician's orders, and she stated there were no parameters included on the orders to hold the blood pressure medication. She stated she recalled the physician verbally telling her to hold the blood pressure medication for a top number (systolic) below 110. LPN #4 was asked to review the physician's orders for Resident #25, and she stated there were no parameters included on the orders to hold the blood pressure medication. She stated the physician verbally told her to hold the blood pressure medication for a systolic bp below 110 and a bottom number (diastolic) below 60. She was unable to recall when she received the order from the physician and stated she has worked at the facility for three years. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045214	A. Building B. Wing	12/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hudson Memorial Nursing Home	700 N. College Avenue 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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 12/18/2024 at 2:26 PM, the Director of Nursing (DON) provided a copy of a document titled PRN [as needed] Medication Standing Orders which was reviewed and did not include any parameters on when to hold a resident's blood pressure medication. On 12/19/2024, LPN #6 was observed as she conducted the 8:00 AM medication pass for residents. At 8:32 AM, she gathered the 8:00 AM medications for Resident #11, entered the room, and administered the medications to the resident, but she did not have the [medication name] (anti-flatulent medication that helps relieve gas symptoms) 80 mg tablets in the cup with the other medications. The medication cup should have had 6 tablets, but only 5 tablets were inside. Resident #11's Order Summary Report was reviewed and indicated a diagnosis of a condition in which the stomach acid flows back up into the tube connecting the mouth and stomach (esophagus) called gastroesophageal reflux disease (GERD for short). The report indicated a physician's order, dated 12/04/2023, for [medication name] (anti-flatulent medication) 80 mg give 1 tablet by mouth one time a day related to GERD. On 12/19/2024 at 9:35 AM, Resident #11's electronic medication administration record (eMAR) was reviewed and indicated [medication name] (anti-flatulent medication) 80 mg give 1 tablet by mouth one time a day. The 0800 (8:00 AM) box for 12/19/2024 included a checkmark with two letters and two numbers. The follow up codes listed on the eMAR indicated the checkmark equaled (=) the medication was administered. There was no list to indicate what the letters and numbers equated. On 12/19/2024 at 9:55 AM, LPN #6 was interviewed with concurrent observations, and she stated there were 5 pills in Resident #11's medication cup. She was asked to review the resident's electronic medication administration record (eMAR) and look at the [medication name] (anti-flatulent medication) order. As she reviewed the eMAR in the computer, she stated she had missed the [medication name] (anti-flatulent medication). She stated she normally checked the medication administration record (MAR) before she goes in [the resident's room] and especially on halls which she normally does not work. She stated the MAR should be checked to make sure all the resident's medications were given. A Medication Administration policy, dated 2016 and provided by the DON, was reviewed and indicated the purpose was to safely and accurately administer physician-ordered medication to each resident. The policy indicated to remember the six rights of correct administration which included the right drug and the right dose. The policy indicated the physician's order must be followed regarding holding medications based on a vital sign parameter.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045214	A. Building B. Wing	12/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hudson Memorial Nursing Home	700 N. College Avenue 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 - Some	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, record review, and facility policy review, the facility failed to ensure medication and/or biologics were properly stored for 2 (Resident #37 and Resident #40) sampled residents. The findings include: 1. A review of the quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 12/06/2024 revealed Resident #40 had a Brief Interview of Mental Status (BIMS) of 14 indicating cognitively intact. a. A plan of care for Resident #40 (revision date 9/18/2024) revealed Resident #40 was dependent on staff for meeting emotional, intellectual, physical, and social needs related to physical limitations. b. On 12/16/24 at 2:40 PM, this surveyor observed Resident #40 lying in bed. This surveyor noted a white cream, in an unlabeled medication cup, on the shelf next to the resident's bed. c. On 12/16/24 the Assistant Director of Nursing (ADON) stated she believed the white cream was a skin barrier cream but could not say that for certain. The ADON stated the white cream in the medication cup should not be on the shelf next to the bed because residents could come in and grab it. 2. A review of the admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 11/14/2024 revealed Resident #37 had a Brief Interview of Mental Status (BIMS) of 15 indicating cognitively intact. a. A plan of care for Resident #37 (revision date 11/8/2024) revealed Resident #37 was dependent on staff for meeting emotional, intellectual, physical, and social needs related to physical limitations. b. On 12/16/24 at 02:24 PM, this surveyor observed Resident #37 lying in bed and noted wound cleanser on the shelf next to the bed. c. On 12/17/24 at 9:30 AM, this surveyor observed Resident #37 lying in bed and noted wound cleanser and antifungal powder on the shelf next to resident's bed. d. On 12/17/24 at 10:00 AM, the ADON stated there was a bunch of items on the shelf next to the resident's bed that should not be there. The ADON stated anything with the label keep out of reach of children should not be out in the open. e. On 12/19/24 at 11:15 AM, the Director of Nursing (DON) stated medications should not be stored in the resident's room accessible to wandering residents. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045214	A. Building B. Wing	12/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hudson Memorial Nursing Home	700 N. College Avenue 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 - Some	f. A review of policy titled Storage of Medications noted ensure that medications are stored in a safe, secure, and orderly manner.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045214	A. Building B. Wing	12/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hudson Memorial Nursing Home	700 N. College Avenue 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 - 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** 51381 Based on observations, interviews, facility document review, and facility policy review, it was determined the facility failed to ensure foods were stored and prepared under sanitary conditions for residents who received foods from one of one kitchen. The total census was 60. The findings are: A) On [DATE] at 11:27 AM during concurrent observations and rounds with the Dietary Manager (DM) all the kitchen walls, including the ones immediately adjacent to the food prep area and above the 3-compartment sink, had brownish-gray, fine, powdery particles extending up to the ceiling. B) On [DATE] at 11:43 AM, the 3-compartment sink was in use by Dietary Employee (DE) #1. DE #1 was interviewed and stated the sanitizer water temperature (temp) for the 3-compartment sink was to be , d+[DATE] degrees Fahrenheit (F), the soapy water side was to be 180 degrees F, and the rinse should be lukewarm. C) On [DATE] at 4:00 PM, DE #2 was observed using the dish machine and stated she has worked at this facility since 2018. DE #2 rinsed the cookware, placed the items into the dish machine, and started the cycle. DE #2 was interviewed and stated she did not perform water temperature checks, the day shift person did. This surveyor and DE #2 observed the instructions on the outside of the machine which indicated the wash and rinse temp is to be a minimum of 120 degrees F. DE #2 was unable to demonstrate or verbalize where the temperature gauge was located or where to test the water using the required test strips. DE #2 placed a test strip in the outside drain reservoir and did not blot the test strip prior to observing the results according to the manufacturer's instructions on the outside of the bottle. D) On [DATE] at 8:53 AM, the contracted pest control representative was observed in the kitchen without a beard cover. The pest control representative's beard was observed to be a full beard and approximately 6 inches in length. E) On [DATE] at 8:55 AM, DE #3 was observed using the dish machine and stated to have worked at the facility for 2 years. The test results observed at 8:55 AM, as reported by DE #3, were as follows: wash temp , d+[DATE] degrees F, rinse temp ,d+[DATE] degrees F. DE #3 stated the minimum temperature of the wash and rinse needed to be 120 degrees F. F) On [DATE] at 9:01 AM and 9:17 AM, the pest control representative was observed walking into the kitchen, past the beard covers available at the door. The beard on the representative was observed to be a full beard, approximately 6 inches in length. G) On [DATE] at 9:03 AM, DE #3 was observed to use the dish machine again. DE #3 stated the wash temperature was 98 degrees F, and the rinse temperature was 110 degrees F. DE #3 was interviewed and stated when the dish machine temperatures were not in range, staff would ask the DM what to do. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045214	A. Building B. Wing	12/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hudson Memorial Nursing Home	700 N. College Avenue 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 - Some	H) On [DATE] at 9:10, DE #2 was observed using the 3-compartment sink. DE #2 was interviewed and stated the hot water tap temperature for the sink fluctuates at times. DE#2 stated sometimes the water must be boiled on the stove and poured into the sink to get the water hot enough. I) On [DATE] at 10:09 AM, the DM was interviewed, and concurrent observations were made by this surveyor: a. The DM stated beard covers were available, beard covers were in their policy for anyone in the kitchen, and the vendor was managed by another person. b. A dish machine cycle was run again by DE #3 with the DM in attendance. The DM stated that maintenance turned up the temperature that goes to the dish machine. The wash temperature was stated to be 110 degrees F and rinse temperature 120 degrees F. Both DE #3 and the DM stated that the temperatures must be a minimum of 120 degrees F for both the wash and rinse cycle, per the manufacturer's instructions posted on the side of the machine. The DM stated it was important that dish machine temps were high enough to ensure the dishes were clean. Review of the manufacturer's instructions provided by the DM state operating temperature of 120F degrees is the minimum, ,d+[DATE]F degrees is recommended c. A test strip was performed by the DM for sanitizer at the 3-compartment sink. The expiration date on the outside of the bottle was ,d+[DATE]. When asked, the DM stated the test strips were expired and it was important that test strips were in date so they could know the sanitization is accurate. d. For the temperatures of the 3-compartment sink, the DM stated that the rinse needed to be hot. e. The DM was asked by this surveyor to wipe the wall with a paper towel. This surveyor observed brownish-gray, fine, powdery particles which transferred to the white paper towel. The DM stated it was dust, and it is important for the walls to be clean, so dust did not float down onto the food. Upon review of the cleaning schedules provided by the DM, there is no allowance seen for cleaning all the walls to remove dust. J) On [DATE] at 3:40 PM, the DM stated all employees who operate the dish machine should know how to test the dish machine temperatures and sanitizer. K) On [DATE] at 5:00 PM, the DM stated the vendor would have to be called about the dish machine temperatures inaccuracy. L) The DM provided a hair covering policy, undated, titled [Facility Name] Policies and Procedures Dietary Department. The document was reviewed and indicated Facial hair on male employees must be covered.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045214	A. Building B. Wing	12/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hudson Memorial Nursing Home	700 N. College Avenue 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 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations and emergencies. 49688 Based on document review and interviews, the facility failed to ensure the facility assessment included pertinent information to assure the necessary care and resources were allocated to meet the needs of the residents. This deficient practice had the potential to affect all residents of the facility. The total census was 60 residents. The findings are: A review of the Facility Assessment Tool, dated 07/11/2024, indicated the assessment was reviewed with the Quality Assessment and Assurance and Quality Assurance and Performance Improvement (QAA/QAPI) committee on 07/12/2024. The facility-wide assessment did not include the following: - An evaluation of what policies and procedures may be required in the provision of care and how the facility would meet the current professional standards of practice. - An evaluation of any contracts, memorandums of understanding including third-party agreements for the provision of goods, services. - Description of how the facility would evaluate their infection prevention and control program that included systems for preventing, identifying, reporting, investigating, and controlling infections. On 12/19/2024 at 11:38 AM, the Administrator was interviewed and stated an entire team contributes to the facility assessment. The Administrator was asked to provide a policy for facility assessment. She stated the facility did not have one.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045214	A. Building B. Wing	12/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hudson Memorial Nursing Home	700 N. College Avenue 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 - Few	Provide and implement an infection prevention and control program. 48977 Based on observations, interviews, record review, and facility policy review, the facility failed to ensure staff applied the proper personal protective equipment (PPE) while providing high contact care to 1 sampled (Resident #3) resident on enhanced barrier precautions (EBP). The findings include: A review of the quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 12/16/2024 revealed Resident #3 had a Brief Interview of Mental Status (BIMS) score of 10 indicating moderate cognitive impairment. Resident #3 was receiving dialysis. A plan of care for Resident #3 (revision date: 6/17/2022) revealed Resident #3 had chronic renal failure, a condition which involves gradual loss of kidney function, related to end stage renal disease (ESRD), a condition where the kidney reaches advanced state of loss of function. On 12/18/2024 at 9:00 AM, this surveyor observed Certified Nursing Assistant (CNA) #10 enter a resident's room. This surveyor observed an Enhanced Barrier Precautions signposted next to the exterior of the door. On 12/18/2024 at 9:10 AM, this surveyor observed CNAs #9 and #10 at the bedside of Resident #3 providing the resident with a bed bath. CNAs #9 and #10 were not wearing a gown during this observation. On 12/18/2024 at 9:30 AM, during an interview, CNA #9 stated a gown, and gloves should be worn when providing care to Resident #3. CNA #9 confirmed neither she nor CNA #10 had a gown in place during the bathing activity for Resident #3. On 12/18/2024 at10:15 AM, during an interview, Licensed Practical Nurse (LPN) #11 stated Resident #3 received dialysis, and the dressing was removed the next day. On 12/19/2024 at 11:17 AM, during an interview, the Director of Nursing (DON) stated staff should wear a gown and gloves when caring for a resident on EBP to help to protect the resident from any infection that could potentially be brought in. A review of policy titled Enhanced Barrier Precautions noted providers and staff must wear gloves and gown for the following high-contact resident care activities: dressing, bathing/showering, transferring, providing hygiene, device care, wound care (any skin opening requiring a dressing).