

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  045220	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  06/27/2024
NAME OF PROVIDER OR SUPPLIER  Fayetteville Health and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE  3100 Old Missouri Rd Fayetteville, AR 72703	

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 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>39316</p> <p>42016</p> <p>49689</p> <p>Based on record review, observation, and interview, the facility failed to ensure residents rights were acknowledged and treated in a manner to promote dignity for 6 (Resident #3, #39, #46, #55, #68, and #95) of 6 sample mix residents.</p> <p>The findings are:</p> <ol style="list-style-type: none"> <li>1. A review of a Face Sheet indicated the facility admitted Resident #39 with diagnoses that included hemiplegia, hemiparesis, and dementia.               <ol style="list-style-type: none"> <li>a. The annual Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 05/10/2024 revealed Resident #39 had a Staff Assessment for Mental Status (SAMS) score of 2, which indicated the resident was moderately impaired for their daily decision making. Skin and ulcer treatments included a pressure relieving device for chair and bed.</li> <li>b. Review of Resident 39's Care Plan, dated 10/23/2017, revealed the resident was at risk for skin breakdown, with interventions that included utilizing pressure reducing cushion while up in chair.</li> <li>c. On 06/24/2024 at 1:13 PM, (Certified Nursing Assistant) CNA #35 assisted Resident #39 into a regular chair from a specialized chair in the dining room. The dining room was full of residents and staff. Resident #39 ' s pants dropped down exposing Resident #39 ' s brief and upper buttocks.</li> <li>d. On 06/27/2024 at 8:30 AM, CNA #12 revealed she was in the dining room the day Resident #39 was transferred from the specialized chair to the dining room chair and saw Resident #39 ' s pants fall down exposing the resident ' s brief and buttocks. CNA #12 revealed Resident #39 had lost a lot of weight and the clothes the resident had on that day were very loose and when they stood Resident #39 up, the pants fell and exposed the brief and buttocks. CNA #12 revealed they should ensure Resident #39 ' s clothes fit better, that is something that should have been addressed before the resident went to breakfast, and it could have been avoided.</li> </ol> </li> </ol> <p>(continued on next page)</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 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>e. On 06/27/2024 at 12:37 PM, the Director of Nursing (DON) revealed that it is the responsibility of the staff member to ensure a resident's dignity is maintained during meal service while transferring from one chair to another.</p> <p>2. A review of the Face Sheet indicated the facility admitted Resident #95 with diagnoses that included neurocognitive disorder with Lewy bodies.</p> <p>a. The Admission MDS with an ARD of 04/09/2024 revealed Resident #95 had a BIMS score of 11, which indicated the resident was had moderate cognitive impairment. Resident #95 required supervision or touching assistance with eating, partial/moderate assistance for oral hygiene, substantial/maximal assistance with upper body dressing and personal hygiene and was dependent with lower body dressing and toileting.</p> <p>b. A review of Resident #95's Care Plan revealed the resident was at risk for aspiration. Interventions included thickened liquids and allowing sufficient time to feed/eat.</p> <p>c. During an observation and interview on 06/24/2024 at 1:11 PM, Resident #95 was sitting in a specialized wheelchair in the dining room. CNA #29 was standing to the left of Resident #95, using a spoon to provide fluid and a fork to place food into Resident #95's mouth. CNA #29 stated Resident #29 has good and bad days and today is unable to eat without assistance.</p> <p>d. During an interview on 06/24/2024 at 1:55 PM, CNA #29 stated they would sit or stand while assisting Resident #95 depending on the height the resident was at. CNA #29 further stated that when Resident #95 eats in their room, and the bed is raised, the CNA would stand to assist. CNA #29 stated they had to stand because there were no additional chairs in the dining room and did not think about getting a chair from the resident's room.</p> <p>e. During an observation on 06/26/2024 at 2:14 PM, Resident #95 was sitting in a specialized wheelchair in the dining room. CNA #13 was standing to the left of Resident #95 placing food and beverage into Resident #95's mouth.</p> <p>f. During an interview on 06/26/2024 at 2:31 PM, CNA #34 stated Resident #95 required assistance with meals and if Resident #95 wanted to eat in their room, CNA #34 sits in the chair to help them eat. If Resident #95 chose to eat in the dining room and it is full, CNAs stand to provide assistance. CNA #34 indicated training was received on dignity and it doesn't matter if CNAs sit or stand to provide assistance. CNA #34 indicated that if Resident #95 required assistance with a meal, Resident #95 would prefer to have someone sit to provide the assistance.</p> <p>g. During an interview on 06/26/2024 at 2:42 PM, CNA #13 stated Resident #95's disease had worsened and they required assistance with eating and it is better to sit and be eye to eye with the resident to see if the Resident is swallowing and not pocketing (holding food in your cheeks). CNA #13 indicated dignity training was received and it was better to sit and feed the resident.</p> <p>h. During an interview on 06/27/2024 at 11:10 AM, Licensed Practical Nurse (LPN) #32 stated residents should be positioned at a 90-degree angle if possible, and staff should sit with the resident if assistance is being provided and should never stand over them and assist due to dignity.</p> <p>(continued on next page)</p>		

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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>i. During an interview on 06/27/2024 at 12:26 PM, the Director of Nursing stated Resident #95 is dependent and requires assistance with meals. When staff provides assistance with meals they should sit and not stand to feed a resident.</p> <p>3. A review of the Face Sheet revealed that Resident #3 had diagnosis of dementia with agitation, bipolar disorder, and schizoaffective disorder.</p> <p>a. A review of the Quarterly MDS with an ARD of 05/30/2024 revealed that Resident #3 scored an 11 (moderately impaired) on the BIMS.</p> <p>b. A review of the Face Sheet revealed that Resident #46 had diagnosis of dementia, delusional disorders, and depressive disorders.</p> <p>c. A review of the Quarterly MDS with an ARD of 04/23/2024 revealed that Resident #46 scored an 8 (moderately impaired) on the BIMS.</p> <p>d. A review of the Face Sheet revealed that Resident #55 had diagnosis of dementia, paranoid disorder, and anxiety disorder.</p> <p>e. A review of the Quarterly MDS' with an ARD of 05/08/2024 revealed that Resident #55 scored a 9 (moderately impaired) on the BIMS.</p> <p>f. A review of the Face Sheet revealed that Resident #68 had diagnoses of dementia, and attention and concentration deficit.</p> <p>g. A review of the Quarterly MDS with an ARD of 05/30/2024 revealed that Resident #68 scored a 7 (severely impaired) on the BIMS.</p> <p>h. On 06/24/2024 at 12:38 PM, Surveyor observed Resident #55 was set up by staff with a lunch tray.</p> <p>i. On 06/24/2024 at 12:42 PM, Resident #46 and Resident #3 were set up by staff with a lunch tray. Resident #68 was observed to be looking at the other residents eating in the dining room.</p> <p>j. On 06/24/2024 at 12:45 PM, Resident #68 stated that they were not thrilled with lunch today. Then stated to the other residents that they were tired of waiting. Resident #68 keeps looking at the doorway for staff to come in with lunch trays and was wringing their hands together while waiting for lunch.</p> <p>k. On 06/24/2024 at 12:51 PM, CNA #28 came into the dining room and set up Resident #68's tray.</p> <p>l. On 06/24/2024 at 12:53 PM, during an interview CNA #28 confirmed the last tray passed was Resident #68 's. CNA stated they were to pass trays table by table, so there is no one sitting there watching others eat. CNA stated the issue for the residents is they are having to wait for food, and it could be dignity as well.</p> <p>(continued on next page)</p>		

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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>m. On 06/25/2024 at 11:52 AM, during an interview Licensed Practical Nurse (LPN) #20 stated generally the procedure for passing trays is table by table so residents will not be watching other residents eat. LPN #20 stated the resident could feel envious of others and that it is a dignity issue.</p> <p>4. A review of the policy Federal Rights of Resident/Guest(s) states Resident/Guest rights. A facility must treat each resident/guest with respect and dignity and care for each resident/guest in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident/guest(s) individuality.</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 42016</p> <p>Based on observations and interviews, the facility failed to ensure walls in residents' rooms were maintained in good repair to provide a clean and homelike environment for residents who resided on 2 (B Hall and D Hall) of 2 halls observed.</p> <p>Findings include:</p> <p>During an observation of room [ROOM NUMBER] on 06/24/2024 at 12:28 PM, the golden colored wall next to the bed was damaged exposing the gypsum compound which is used to patch and fix drywall and was exposed from under the paint in white irregular shaped areas visible above the edge of the side of the bed.</p> <p>The edge of the door to the resident ' s bathroom had chipped paint and rough cracked areas with brown debris in the cracks on the edge of the door, above and below the handle and on the door jam. There was a gouged area in the middle of the door exposing raw wood.</p> <p>The toilet seat on the toilet in the resident ' s bathroom was peeling and had yellow, brown and black staining covering the top where resident would sit on the toilet.</p> <p>During an observation on 06/24/2024 at 1:52 PM, the doorknob to room [ROOM NUMBER] was loose and the escutcheon plate was not seated and was falling forward against the door handle interfering with operation of the door handle.</p> <p>During an observation of room [ROOM NUMBER] on 06/25/2024 at 8:56 AM, inside the room on the left side of the door opening just over the threshold, the brown tile had an oval shaped area missing tile and exposing the concrete floor below. There were lines around the missing tile in a cracked type of pattern extending across to another tile.</p> <p>The bathroom sink in room [ROOM NUMBER] was missing the drain cover and had damage in a cracked pattern spreading outward around the drain and across the bottom of the sink. The area around the exposed drain and bottom of the sink in cracks contained a brownish black gritty substance.</p> <p>The wall to the right side of bed B was damaged, from the level of the top of the headboard extending toward the floor, both vertically and horizontally in an irregular, scrape/scratch like pattern with white patches and peeling paint, exposing the gypsum compound which is used to patch and fix drywall and was exposed from under the paint. The resident did not understand why the wall could not be fixed and stated, It makes me feel like they don't care about me.</p> <p>During an interview on 06/25/2024 at 8:59 AM, Certified Nursing Assistant (CNA) #18 stated the floor of room [ROOM NUMBER] was a fall risk because of the damaged tile and the damage needed repair. CNA #18 stated the bathroom sink has grit in the bottom that could be felt, and the sink was stained.</p> <p>(continued on next page)</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 06/25/2024 at 3:20 PM, Maintenance stated there are two maintenance log books, one white and one black at the nurses ' station, but Maintenance was unable to locate the log books.</p> <p>During an interview on 06/26/2024 at 9:41 AM, Maintenance was asked if the facility had a maintenance program or schedule. Maintenance stated rounds are done monthly, two halls per month and a monthly calendar is used to track what rooms needed repairs. Damaged walls, leaking bathrooms, and other things are fixed in an order from worst to least. If a room is bad and the resident refuses to allow maintenance to work on it, the repairs are not done until there is a room change or a discharge. Maintenance stated notification of needed repairs is done by the person requesting the repair.</p> <p>During a concurrent observation and interview on 06/26/2024 at 9:44 AM, in room [ROOM NUMBER], Maintenance stated the wall behind bed B needed to be textured, sanded, and painted. The floor has a missing chunk of tile about 1.5 inches by 2.0 inches and 1/8th inch deep. Maintenance reported the tile will have to be cut out and replaced. Maintenance was asked if the floor was safe for residents in the room and stated if the floor is not repaired it would be bumpy and there is a concern it would destabilize their walker.</p> <p>During a concurrent observation and interview with Maintenance in room [ROOM NUMBER], Maintenance stated the toilet seat was replaced at 4:30 PM on 06/24/2024 after the surveyor had been in the room. Maintenance stated the toilet seat was worn out and he would not have sat on the seat to use the bathroom.</p> <p>Maintenance stated the bathroom door in room [ROOM NUMBER] was scuffed up and needed to be painted to cover the chipped and gouged area.</p> <p>Maintenance stated the wall, next to the side of the bed, in room [ROOM NUMBER] needed to be textured and painted.</p> <p>During a concurrent observation and interview in room [ROOM NUMBER], Maintenance stated the handle to the room door was loose and the screw that goes under the cap is loose ad needs to be tightened. When asked what should be done, Maintenance stated the handle needed to be replaced because if the door was closed and the handle fell off, they would have to pick up the handle, put it back on and turn it to open it.</p> <p>During a concurrent observation and interview, on 06/26/2024 at 10:23 AM, the Administrator was asked if the facility had a maintenance program or maintenance schedule. The Administrator stated if a room is vacant, they go in and do repairs. If repairs require a resident to be relocated, they do that if the resident agrees.</p> <p>In room [ROOM NUMBER], the Administrator was asked if the wall in the room was acceptable. The Administrator stated the damage would be addressed and resident may have to be relocated if the resident agrees.</p> <p>The Administrator was aware of the floor damage and stated Maintenance was previously asked to address the floor damage, and the damage could be a hazard with use of the walker.</p> <p>The Administrator opened the bathroom door and stated the sink would be looked at as well.</p>		

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives an accurate assessment.</p> <p>49689</p> <p>Based on observations, record review, and interview the facility failed to ensure a Minimum Data Set (MDS) was accurately coded for 1 (Resident #89) sampled resident.</p> <p>The findings are:</p> <p>A review of the Face Sheet revealed that Resident #89 had a diagnosis of amyotrophic lateral sclerosis (ALS)</p> <p>A review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 05/321/2024 revealed that Resident #89 had a Staff Assessment of Mental Status (SAMS) completed that revealed had a memory problem for long-term and short-term memory. A review of Section GG revealed that it was coded for one upper extremity with limited range of motion.</p> <p>A review of the Care Plan for Resident #89 revealed no interventions for limited range of motion.</p> <p>On 06/24/2024 at 11:58 AM, the Surveyor observed both of Resident #89 ' s hands contracted with the fingers touching the forearms, no interventions are in place.</p> <p>On 06/25/2024 at 9:40 AM, Surveyor observed no interventions in place for the contractures.</p> <p>On 06/25/2024 at 2:37 PM, during an interview with Certified Nursing Assistant (CNA) #24, CNA #24 stated when Resident #89 was first admitted to the facility, rolled washcloths and stretches were used to treat the contractures. CNA #24 stated that they have moved to D hall for the last few months and that they remembered no charting for contractures.</p> <p>On 06/25/2024 at 2:45 PM, during an interview CNA #20 stated that they are familiar with Resident #89 and worked this hall often and cannot think of any charting for the contractures. CNA #20 stated during care they do range of motion stretches and attempt washcloths, but it is difficult with the level of contracture the resident has.</p> <p>On 06/27/2024 at 8:26 AM, during an interview the MDS Coordinator stated the most recent MDS is coded for one upper extremity in section GG, limited range of motion. MDS Coordinator stated can we go look at the resident, I am not sure if that is correct. The MDS Coordinator confirmed on observation that the MDS was not correctly coded, the resident has two contractures, then stated the MDS is important to ensure care plans are accurate, and the resident summary is as well. The MDS Coordinator stated that they just recently switched to this position but stated that the criteria is if the resident cannot do full range of motion, it is limited in some capacity.</p> <p>On 06/27/2024 at 8:50 AM, during an interview the Director of Nursing stated that the MDS is the most thorough assessment for the residents. It is important to have an accurate MDS to care for the resident properly.</p> <p>(continued on next page)</p>		

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A review of the facility policy Resident Assessment Instrument (RAI) revealed Purpose: Residents are assessed, using a comprehensive assessment process, in order to identify care needs and to develop a plan of care; Standard: According to federal regulations the facility conducts initially and periodically a comprehensive, accurate, and standardized assessment of each resident's functional capacity.</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p>49689</p> <p>Based on observation, record review, and interview the facility failed to ensure care plans were revised for 2 of 2 sampled Residents (Resident #78 and #89).</p> <p>The findings are:</p> <ol style="list-style-type: none"> <li>1. A review of the Face Sheet reveals that Resident #78 had diagnoses of severe intellectual disabilities and developmental disorders.               <ol style="list-style-type: none"> <li>a. A review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date of 06/06/2024 showed Resident #78 had a Staff Assessment of Mental Status (SAMS) completed that reveals memory problem for long-term and short-term memory.</li> <li>b. A review of the Care Plan revealed an intervention of resident door open at all times for easy visualization related to inability to utilize call light. No other interventions are in place for the recent removal of the call light.</li> <li>c. On 06/24/2024 at 11:36 AM, Surveyor observed Resident #78 sitting on bed crossed legged with the call light going off continuously and no call light located on Resident #78 ' s side of the room or plugged into the board on the wall.</li> <li>d. On 06/24/2024 at 12:00 PM, during an interview Certified Nursing Assistant (CNA) #28 stated it has only been like this a few days, We had to take the call light away as the resident kept wrapping it around their neck. CNA #28 stated Resident #78 ' s roommate will usually ring a bell as a way for them to know that they need care. CNA #28 stated this behavior from Resident #78 is normal, and They pull the call light out of the wall consistently.</li> <li>e. On 06/24/2024 at 2:00 PM, Surveyor observed the call light still going off continuously.</li> <li>f. On 06/25/2024 at 10:00 AM, Surveyor observed the call light still going off continuously.</li> <li>g. On 06/26/2024 at 9:00 AM, Surveyor observed a plug has been put into place, Resident #78 does not have a call light at this time.</li> <li>h. On 06/26/2024 at 9:05 AM, during an interview with CNA #28 stated the call light was fixed yesterday afternoon, and that Resident #78 does not have a call light. CNA #28 stated Resident #78 is non-verbal but that they do frequent rounds and watch for cues with Resident #78 to provide care.</li> <li>i. On 06/27/2024 at 8:26 AM, during an interview with the MDS Coordinator confirmed that there were no interventions for the removal of the call light in the care plan. MDS Coordinator stated that a comprehensive care plan was important as the resident could go without needs being met.</li> </ol> </li> <li>2. A review of the Face Sheet revealed that Resident #89 had a diagnosis of Amyotrophic Lateral Sclerosis (ALS).</li> </ol> <p>(continued on next page)</p>

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>a. A review of the Quarterly MDS with an ARD of 05/321/2024 reveals that Resident #89 had a SAMS completed that revealed the resident had a memory problem for long-term and short-term memory.</p> <p>b. A review of the Care Plan revealed no interventions for limited range of motion.</p> <p>c. On 06/24/2024 at 11:58 AM, Surveyor observed both of Resident #78 ' s hands were contracted with the fingers touching the forearms, no interventions are in place.</p> <p>d. On 06/25/2024 at 9:40 AM, Surveyor observed no interventions in place for the contractures.</p> <p>e. On 06/25/2024 at 2:37 PM, during an interview with CNA #24 stated when Resident #89 was first admitted to facility rolled washcloths and stretches were used. CNA then stated that they have moved to D hall for the last few months and that they remembered no charting for contractures.</p> <p>f. On 06/25/2024 at 2:45 PM, during an interview with CNA #20 stated that they are familiar with the resident and work this hall often and can think of no charting for the contractures. CNA #20 stated during care they do range of motion stretches and attempt washcloths, but it is difficult with the level of contracture the resident has.</p> <p>g. On 06/27/2024 at 8:26 AM, during an interview the MDS Coordinator confirmed that no interventions were in place for contractures on the care plan and stated that it is important to have an accurate care plan so staff know how to care for the resident, such as skin integrity in this case, or even know not to try and stretch the contractures too far. Interventions can help prevent worsening of limited range of motion.</p> <p>h. On 06/27/2024 at 08:50 AM, during an interview the Director of Nursing (DON) stated it is important to have an accurate care plan. It is an expected part of their maintenance and that way staff know how to bridge the gap for care.</p> <p>3. A review of the facility policy Person Centered Care Plans revealed When a new approach or goal is identified, the entry should be dated using the date the goal/approach is entered on the care plan.</p>		

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NAME OF PROVIDER OR SUPPLIER  Fayetteville Health and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE  3100 Old Missouri Rd Fayetteville, AR 72703	

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>39316</p> <p>Based on record review, observation, and interview, the facility failed to ensure interventions to prevent pressure ulcers to prevent skin breakdown or worsening of skin issues, were utilized for 1 (Resident #39) of 1 sampled resident. The findings are:</p> <ol style="list-style-type: none"> <li>1. A review of a Face Sheet indicated the facility admitted Resident #39 with diagnoses that included hemiplegia, hemiparesis, and dementia. <ol style="list-style-type: none"> <li>a. The annual Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 05/10/2024 revealed Resident #39 had a Staff Assessment for Mental Status (SAMS) score of 2, which indicated the resident moderately impaired for their daily decision making. Skin and ulcer treatments included a pressure relieving device for chair and bed.</li> <li>b. Review of Resident 39's Care Plan, dated 10/23/2017, revealed the resident was at risk for skin breakdown, with interventions that included utilizing a pressure reducing cushion while up in chair.</li> <li>c. On 06/24/2024 at 1:10 PM, Resident #39 observed sitting in a specialized chair in the dining room. There was no cushion in Resident #39 ' s specialized chair.</li> <li>d. On 06/25/2024 at 12:15 PM, Resident #39 observed sitting in a specialized chair in the dining room. There was not a cushion in Resident #39 ' s specialized chair. Resident #39 was sitting on the plastic straps.</li> <li>e. On 06/25/2024 at 12:31 PM, Resident #39 observed sitting in a specialized chair in the dining room. There was no cushion in Resident ' s specialized chair. Resident was sitting directly on the plastic straps.</li> <li>f. On 06/25/2024 at 12:53 PM, Resident #39 observed sitting in a specialized chair in the dining room. There was no cushion in Resident #39 ' s specialized chair. The Resident was sitting on plastic straps.</li> <li>g. On 06/25/2024 at 6:03 PM, Certified Nursing Assistant (CNA) #31 and CNA #1 was observed to transfer Resident # 39 from the dining chair to a specialized chair using a gait belt. CNA #31 and CNA #1 lifted Resident #39 and transferred into the specialized chair. There was no cushion in the specialized chair. Resident #39 was sitting on thick plastic/rubber straps. CNA #31 revealed during an interview that she did not know if Resident #39 was supposed to have a cushion in their wheelchair as she did not work that hall.</li> <li>h. On 06/25/2024 at 01:45 PM, during an interview CNA #17 revealed that most of the specialized chairs have a cushion, but Resident #39 did not have one and I don't know why, and that cushions were put in specialized chairs to prevent skin breakdown.</li> </ol> </li> </ol> <p>(continued on next page)</p>

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>i. On 06/27/2024 at 8:30 AM, CNA #12 revealed during an interview that Resident #39 had not had a cushion in the Resident #39 ' s specialized chair and a corporate lady gave her a cushion this morning and asked if she would put it in Resident # 39 chair.</p> <p>j. On 06/27/2024 at 12:37 PM, the Director of Nursing (DON) revealed during an interview that she did not know why Resident #39 did not have a cushion in the specialized chair and all care staff is responsible for ensuring pressure relieving devices are in residents' chairs.</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>39316</p> <p>49689</p> <p>Based on record review, observation, and interview, the facility failed to ensure a transfer lift was properly working to prevent the potential for harm for 2 (Resident #76 and Resident #79) of 2 sampled residents; and the facility failed to ensure chemicals were contained / stored when not in use to prevent the possible ingestion and injury for 1 (Resident #32) sampled resident.</p> <p>The findings are:</p> <ol style="list-style-type: none"> <li>1. A review of a Face Sheet indicated the facility admitted Resident #32 with a diagnosis of dementia. <ol style="list-style-type: none"> <li>a. A review of a quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 04/25/2024 revealed Resident #32 had scored a 12 on a Brief Interview for Mental Status, indicating moderate cognitive impairment.</li> <li>b. On 06/25/2024 at 5:27 PM Resident # 32 observed lying in bed. A canister of disinfecting wipes was observed on resident nightstand.</li> <li>c. On 06/25/2024 at 5:30 PM, Licensed Practical Nurse (LPN) #19 was asked about the disinfecting wipes and revealed it was possible the resident's family brought them in, and it was a hazard and dangerous to leave those items in the resident's room.</li> <li>d. On 06/27/2024 12:37 PM, the Director of Nursing (DON) revealed during an interview that disinfecting wipes should be stored in the supply room or the bottom drawer of the medication cart because it is a chemical and should be out of reach of people who should not have them.</li> </ol> </li> <li>2. On 06/25/2024 at 9:00 AM, Surveyor observed a transfer lift on D hall missing the upper right and lower right metal moveable attachments. <ol style="list-style-type: none"> <li>a. On 06/25/2024 at 2:19 PM, Surveyor observed a lift transfer with Resident #76, Certified Nursing Assistant #21 (CNA) and CNA #18. Surveyor observed the transfer, with both moveable attachments missing.</li> <li>b. On 06/25/2024 at 2:52 PM. during an interview CNA #18 stated that their last training was in school nine years ago, and that they have been at the facility for over a year. CNA #18 then stated that the lift was the only one throughout the building and if it breaks, they page for Maintenance at the nurse's station. CNA #18 stated that the residents have to wait their turn for the lift, when it gets really busy.</li> <li>c. On 06/25/2024 at 2:52 PM, during an interview with Maintenance he stated that I have a paper log, but I do not keep the papers. Then stated that Everybody has my number, usually they text me night and day what is needed throughout the building, I am on call 24/7.</li> </ol> </li> </ol> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>d. On 06/25/2024 at 6:22 PM, during an interview CNA #22 stated, I was last trained during school in 2011, and some new jobs require us to do a demonstration. CNA#22 then stated if any issues arise, I go directly to my nurse after that I go to the maintenance book and mark it down.</p> <p>e. On 06/25/2024 at 6:43 PM, CNA #27 was interviewed and revealed the last time she had training on the lifts was about 6-7 months ago during CNA classes, and she reports issues with the lift to the maintenance man, and he takes care of it.</p> <p>f. On 06/25/2024 at 6:45 PM, the surveyor observed the transfer of Resident #79 from wheelchair into bed with missing clips, during the transfer the right top hanger a missing moveable metal attachment is missing, the strap moved up and came close to slipping out. During an interview CNA #22 and CNA #23 agreed they have never noticed the missing metal attachments on the transfer lift. CNA #22 then stated that now they realized it has been like that for a month and half.</p> <p>g. On 06/25/2024 at 6:45 PM, during an interview CNA #25 stated the last training for the mechanical lift was about 2 months ago and was on how to properly use the lift.</p> <p>h. On 06/25/2024 at 7:20 PM, during an interview Licensed Practical Nurse (LPN) #26 reported working nights at the facility for 5 months, and stated the lift is checked by maintenance regularly and if there were any issue maintenance would take care of it.</p> <p>i. On 06/25/2024 at 7:22 PM, during an interview Maintenance stated they inspected the lifts once a month and offered the inspection logs. Maintenance confirmed they were trained to inspect the lifts and stated the issues they saw were no rubber skids on top of the legs at the base, and the two missing clips, on one the top right and one on the bottom left. The issue is that if somebody pulls on it or if it is not properly positioned it could slip and a resident could get hurt.</p> <p>j. On 06/25/2024 at 7:30 PM, during an interview Registered Nurse #3 (RN) stated if the lift is in use and works, it is safe to use. If it wasn't safe, it would have been taken out of service.</p> <p>k. On 06/25/2024 at 8:10 PM, during an interview the Director of Nursing (DON) stated they train staff annually on lift usage. Any issues are to be reported to a member of management or maintenance and if the lift is used when it is broken, it could lead to injury.</p> <p>l. A review of the facility policy Lifting Device Policy states to 2. Follow manufacturer's directions for specific lift or repositioning device usage.</p> <p>m. A review of the Named Lift 50/600 RPL450-2, RPL600-2 Battery- Powered Patient Lift User Manual indicated, DO NOT move the patient if the sling is not properly connected to the hooks of the hanger bar. When the sling is elevated a few inches off of the stationary surface and before moving the patient, check again to make sure the sling is properly connected to the hooks of the hanger bar. If any attachments are NOT properly in place, lower the patient back onto the stationary surface and correct this problem; otherwise, injury or damage may occur.</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>49689</p> <p>Based on observation, record review, and interview the facility failed to ensure that physicians orders were followed for oxygen therapy for 1of 1 Resident #89 sampled resident. These are our findings:</p> <p>A review of the Face Sheet revealed that Resident #89 had diagnosis of amyotrophic lateral sclerosis (ALS).</p> <p>A review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 05/321/2024 reveals that Resident #89 had a Staff Assessment of Mental Status (SAMS) completed that revealed had a memory problem for long term and short-term memory.</p> <p>A review of the Care Plan states that the care plan goal is Resident #89 Will exhibit no shortness of breath, and interventions include administer oxygen therapy as ordered.</p> <p>A review of the Physicians Order List revealed Resident #89 had a physician's order for oxygen 2 liters per minute via nasal cannula for shortness of breath.</p> <p>On 06/24/2024 at 11:58 AM, Surveyor observed Resident #89 had uneven labored respirations, the oral cavity is red and cracked from mouth breathing. Surveyor observed Resident #89's oxygen concentrator set to 1 liter per minute (LPM).</p> <p>On 06/25/2024 at 9:40 AM, Surveyor observed Resident #89 had uneven labored respirations and the oral cavity is cracked from mouth breathing. Surveyor observed Resident #89's oxygen concentrator set to 1 LPM.</p> <p>On 06/25/2024 at 9:50 AM, during an interview Licensed Practical Nurse #19 (LPN) confirmed that Resident #79 ' s oxygen was reading in-between 1 liter per minute (LPM) and 1.5 LPM. LPN #19 confirmed that the order was for 2 LPM for the resident. LPN #19 stated not following a physician's order can lead to death, discomfort, or struggling, especially this resident as they are on Hospice and comfort is the goal.</p> <p>On 06/26/2024 at 08:50 AM, during an interview the Director of Nursing (DON) stated it's important to follow physician orders to meet their care needs. The DON stated that not following a physician order for a resident could lead to incorrect care.</p> <p>A review of the facility policy Oxygen Administration states that Oxygen should be administered under orders of the attending physician. Process: 1. Obtain physician's orders for the rate of flow and route of administration of oxygen.</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>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.</p> <p>39316</p> <p>48630</p> <p>Based on observation, interview, and record review the facility failed to ensure expired bubble pack medications were removed from the medication cart once the expiration date has been reached for 3 of 5 medications carts checked for review, the facility failed to ensure controlled substances were properly removed once the seal to the medication had been broke to prevent the possible misappropriation of medication for 1 of 3 medication carts checked for review, the facility failed to ensure that medications were stored and labeled out of resident reach for 1 (Resident #32) of 1 residents.</p> <p>The findings are:</p> <p>1. On 06/27/2024 at 09:51 AM Surveyor checked E Hall Cart for compliance with Licensed Practical Nurse (LPN) #33. The findings are:</p> <p>(1) bubble pack card of Ibuprofen 600 mg (milligram)tablets with an expiration date of 10/17/2023 with 13 pills remaining</p> <p>(1) bubble pack card of Ibuprofen 600 mg tablets with an expiration date of 10/17/2023 with 12 pills remaining</p> <p>(1) bubble pack card of Hyoscyamine 0.125 mg sublingual tablets with an expiration date of 05/10/2024 with 30 pills remaining</p> <p>(1) bubble pack card of Ondansetron 4 mg tablets with an expiration date of 05/10/2024 with 24 pills remaining</p> <p>(1) bubble pack card of hydrochlorothiazide 25 mg tablets with an expiration date of 05/30/2024 with 29 pills remaining</p> <p>During an interview on 06/27/2024 at 9:51 AM, the LPN #33 stated medication carts are checked every few weeks and corporate came in on 06/20/2024 and checked the medication carts for any expired medications. LPN #33 also stated medication carts are checked to ensure that residents do not receive expired medications.</p> <p>2. On 06/27/2024 at 10:04 AM Surveyor checked D Hall Cart for compliance with LPN #33. The findings are:</p> <p>(1) bubble pack card of hydroxyzine hcl (Hydrochloric Acid) 25 mg tablets with an expiration date of 05/29/2024 with 3 pills remaining</p> <p>(1) bubble pack card of hydroxyzine hcl 25 mg tablets with an expiration date of 05/07/2024 with 7 pills remaining</p> <p>(continued on next page)</p>

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>(1) bubble pack card of ondansetron hcl 4 mg tablets with an expiration date of 05/22/2024 with 3 pills remaining</p> <p>(1) bubble pack card of Hyoscyamine 0.125 mg sublingual tablets with an expiration date of 05/29/2024 with 27 pills remaining</p> <p>3. On 06/27/2024 at 10:18 AM Surveyor checked A Hall Cart for compliance with LPN #19. The findings are:</p> <p>(1) bubble pack card of Oxybutynin chloride 5mg tablets with an expiration date of 05/03/2024 with 7 pills remaining</p> <p>(1) bubble pack card of Urogesic- blue tablets with an expiration date of 04/30/2024 with 28 pills remaining</p> <p>(1) bubble pack card of oxybutynin chloride 5 mg tablets with an expiration date of 04/11/2024 with 3 pills remaining</p> <p>(1) bubble pack card of oxybutynin chloride 5 mg tablets with an expiration date of 04/11/2024 with 7 pills remaining</p> <p>(1) bubble pack card of oxybutynin chloride 5 mg tablets with an expiration date of 05/03/2024 with 7 pills remaining</p> <p>During an interview on 06/27/2024 at 10:18 AM, LPN #19 stated the medication carts are checked at least monthly, but the as needed medications are not checked unless the Pharmacist is here. LPN #19 also stated that medication carts are checked to ensure that residents do not receive expired medications, remove the cards if no longer taking, and to ensure they have the prescribed medication available.</p> <p>4. On 06/27/2024 at 10:18 AM Surveyor reconciled controlled substances on Medication cart A and B with LPN #19. The findings are:</p> <p>(1) bubble pack card of clonazepam 0.5 mg tablets with 15 tablets remaining with a broken seal on pill #4</p> <p>(1) bubble pack card of Morphine sulfate 15 mg ER tablets with 14 tablets with a taped in pill on pill #14</p> <p>(1) bubble pack card of diazepam 5 mg tablets with 47 tablets remaining with a broken seal on pill #9, 10, 20</p> <p>(1) bubble pack card of Tramadol 50 mg tablets with 6 tablets with a taped in pill on pill #6</p> <p>During an interview on 06/27/2024 at 10:18 AM, the LPN #19 stated controlled substance pills should be wasted once the seal is broken by two nurses and signed out in the controlled substance book because you don't know for sure what pill is in there. It's the point of the seal.</p> <p>(continued on next page)</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>5. During an interview on 06/27/2024 at 11:05 AM, the Director of Nursing (DON) stated during count of controlled substance medications the nurses should be checking for breaks in the seal. Once the seal is broken the nurse needs to secure the break, the nurse can remove the pill and waste it, or it can be taped by the nurse. The DON stated this is to ensure there are no missing medications. The DON stated medication carts are checked monthly by the Pharmacists which were in the facility and checked carts on 06/26/2024 and the corporate quality assurance consultant checks the carts quarterly. The medication carts are checked to ensure the residents do not receive an expired medication.</p> <p>6. A review of a facility policy titled, Storage of Medications and Biologicals, dated 04/20 indicated, Outdated, contaminated, or deteriorated medications and those in containers that are cracked, soiled, or without secure closures are removed from stock, disposed of according to procedures for medication disposal, and reordered from the pharmacy, if a current order exists.</p> <p>7. A review of a Face Sheet indicated the facility admitted Resident #32 with a diagnosis that included dementia.</p> <p>a. A review of a quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 04/25/2024 revealed Resident #32 had scored a 12 on a Brief Interview for Mental Status, indicating moderate cognitive impairment.</p> <p>b. On 06/24/2024 at 11:45 AM, Resident #32 lying in bed. A bottle of 5% eye solution was on the bedside table. Resident # 32 states they do not self-administer eye drops and does not take eye drops.</p> <p>c. On 06/25/2024 at 5:27 PM, Resident #32 was observed lying in bed. An unlabeled medicine cup containing a white cream substance was observed on resident nightstand. Resident #32 was asked what the cream was used for. Resident #32 stated, They use it on my legs I guess.</p> <p>d. On 06/25/2024 at 5:30 PM, LPN #19 was asked if Resident #32 had an order for eye drops. LPN #19 revealed Resident #32 did not have an order for the eye drops. LPN #19 revealed she did not know what the cream was in the medicine cup, and that it was a hazard and dangerous to leave those items in the resident's room.</p> <p>e. On 06/25/2024 at 5:37 PM, LPN #36 revealed during an interview that the cream in the unlabeled medicine cup looked like barrier cream, but could not say for sure, and that it should not be left in a resident room because they could ingest it.</p> <p>f. On 06/27/2024 at 12:37 PM, during an interview the DON revealed medications should be stored in the medication room, medication carts, or treatment carts so they are not in reach of people who should not have them.</p>		

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<p>F 0803</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</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 2 of 2 meals observed. The failed practices had the potential to affect 7 residents who received pureed diets, 1 resident who received pureed meat only, 60 residents who received regular diets and 30 residents who received mechanical soft diets from 1 of 1 kitchen.</p> <p>The findings are:</p> <ol style="list-style-type: none"> <li>1. The 06/25/2024 supper menu documented the residents who received pureed diets were to receive 3-ounce of chicken salad and 4-ounce (1/2 cup) of pureed country macaroni salad and for the residents on regular diets were to receive 3/4 cup of toss salad with dressing.</li> <li>2. On 06/25/2024 at 5:26 PM, the following observations were made during the supper meal service. <ol style="list-style-type: none"> <li>a. Dietary Aide #7 used a tong to serve a small portion of toss salad to the residents on regular diets.</li> <li>b. Dietary [NAME] (DC) #6 served mashed potatoes to the residents on pureed diets, instead of pureed country macaroni salad. At 06:05 PM, the surveyor asked DC #6 the reason residents on pureed diets did not receive pureed macaroni salad. DC #6 stated, Bunch of people like mashed potatoes. We should have followed the menu.</li> <li>c. 06/25/24 6:03 PM, the surveyor asked Dietary aide (DA) #7 to measure the same amount of toss salad that she had served to the residents for supper. DC #7 placed the same amount of toss salad on a plate and transferred it into a 4-ounce spoon and stated, They supposed to have 4 ounces. The surveyor asked Dietary aide (DA) #7 if she reviewed the menu before serving supper meal. DA #7 stated, No, I thought they were supposed to have 1/2 cup.</li> </ol> </li> <li>3. The 06/26/2024 noon menu documented the residents who received pureed diets were to receive 2 ounce (1/4 cup) of pureed dinner roll. <ol style="list-style-type: none"> <li>a. On 06/26/24 at 1:08 PM, the residents on pureed diets were not served pureed dinner rolls.</li> <li>b. On 06/26/24 at 1:10 PM, the surveyor asked DC #11 the reason residents on pureed diets did not receive pureed dinner rolls. DC #11 stated, I forgot.</li> </ol> </li> </ol>		

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NAME OF PROVIDER OR SUPPLIER  Fayetteville Health and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE  3100 Old Missouri Rd Fayetteville, AR 72703	
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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>Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature.</p> <p>03508</p> <p>Based on observation, record review, and interview the facility failed to ensure food was prepared by methods that maintained appearance; hot foods were served hot and cold foods were served cold to maintain palatability and encourage adequate nutritional intake for 1 of 1 meal observed on the B Hall and C Hall. The failed practice had the potential to affect 14 residents who received meal trays in their room on B Hall and 18 residents who received meal trays in their rooms on A-Hall.</p> <p>The findings are:</p> <p>1. On 06/24/2024 at 2:53 PM, Resident #29 stated the food is always cold when asked if the hot food is hot when received to the room on a tray.</p> <p>2. On 06/25/2024 at 1:42 PM, an unheated cart that contained trays for lunch was delivered to the B Hall by Certified Nursing Assistant (CNA) #14. 06/26/24 2:02 PM, immediately after the last resident received their tray in their room on B-Hall (Unit), the temperatures of the food items on a test tray from the food cart were checked by the Dietary Manager and read by Certified Nursing Assistant #13. The results were as follows:</p> <p>a. Ground ham with gravy - 92 degrees Fahrenheit.</p> <p>b. [NAME] yam - 80 degrees Fahrenheit.</p> <p>c. Cut green beans - 100 degrees Fahrenheit.</p> <p>d. Ham - 99 degrees Fahrenheit.</p> <p>2. On 06/26/2024 at 5:24 PM, an unheated food cart that contained 23 trays for supper was delivered to A Hall by the Certified Nursing Assistant #15. At 5:41 PM, immediately after the last resident received their tray in their room on A-Hall, the temperatures of the food items on a test tray from the food cart were checked by the Dietary Manager and read by Licensed Practical Nurse (LPN) #16. The results were as follows:</p> <p>a. Potato salad - 60 degrees Fahrenheit.</p> <p>b. Ground riblets 90 degrees Fahrenheit.</p> <p>c. Riblets 99 degrees Fahrenheit.</p>		

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<p>F 0805</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs.</p> <p>03508</p> <p>Based on observation and interview, 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 failed practice had the potential to affect 7 residents who received pureed diet, and one resident who received pureed meat only.</p> <p>The findings are:</p> <ol style="list-style-type: none"> <li>1. On 06/25/2024 at 4:53 AM, the following observations were made on the steam table:               <ol style="list-style-type: none"> <li>a. A pan of pureed cut green beans, the consistency was runny.</li> <li>b. A pan of pureed chicken, the consistency was gritty, not smooth, and had water in the mixture.</li> <li>c. A pan of pureed beef sauce, the consistency was running.</li> </ol> </li> <li>2. On 06/25/2024 at 6:28 PM, the surveyor asked the Dietary Manager to describe the consistency of the pureed food items served to the residents on pureed diets at supper meal. She stated, Pureed cut green beans look like nectar. Pureed chicken was gritty and pureed beef sauce was watery.</li> <li>3. On 06/26/2024 at 7:14 AM, the following observations were made on the steam table:               <ol style="list-style-type: none"> <li>a. A pan of pureed oatmeal. The consistency was thick.</li> <li>b. A pan of biscuit. The consistency was lumpy.</li> <li>c. A pan of pureed sausage. The consistency was gritty and not smooth. Pieces of bread were visible in the mixture.</li> <li>d. A pan of cream of wheat. The consistency was watery.</li> </ol> </li> <li>4. On 06/26/2024 at 7:26 AM, the surveyor asked Dietary Manager to describe the pureed food items served to the residents on pureed diet for breakfast. She stated, Pureed sausage was gritty and had pieces of bread in it. Pureed biscuit was lumpy, and pureed oatmeal was thick.</li> <li>5. On 06/26/2024 at 11:11 AM, Dietary [NAME] (DC) #11 used a #12 scoop to place 8 servings of diced ham into a blender, added broth and pureed. She poured the pureed ham into a pan and placed it on the steam table. The consistency of the pureed ham was runny.</li> <li>6. On 06/26/2024 at 12:00 PM, DC #11 used a #6 scoop to place 6 servings candy yam into a blender, added a little water, garlic powder and pureed. She poured the pureed yam into a pan and placed it on the steam table. The consistency of the pureed yam was runny.</li> </ol> <p>(continued on next page)</p>

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<p>F 0805</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>7. On 06/26/2024 at 12:23 PM, DC #11 placed 8 servings of spinach with eggs into a blender, added broth and pureed. She poured it into a pan and placed it on the steam table. The consistency was runny.</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>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>42016</p> <p>Based on observation, interview, and record review the facility failed to ensure food stored in the refrigerator, freezer, and storage room were labeled and dated and expired food items and left over foods were promptly removed from stock; and ensure employees avoided the use of alcohol-based hand rub (ABHR)/hand sanitizer gel in lieu of proper handwashing during food distribution, in 1 of 1 kitchen observed. These failed practices had the potential to affect 99 residents who received meals from the 1 of 1 kitchen.</p> <p>The findings are:</p> <p>1. On [DATE] at 11:16 AM, the following observations were made:</p> <p>a. Two clear plastic disposable containers of a smooth brown substance, covered with a clear lid, contained no description of contents or date. The Dietary Manager stated it was gravy and should have been labeled. The Dietary Manager removed the items from the refrigerator and placed them in trash can outside door of refrigerator.</p> <p>b. A clear plastic food storage container was not labeled or dated. Dietary Manger identified the contents as chocolate frosting.</p> <p>c. An individual container of yogurt was located on a metal shelf and did not contain a resident's name. The Dietary Manager stated it was for a resident but did not know the resident's name. The container had a handwritten date of ,d+[DATE].</p> <p>d. A clear plastic food storage container was labeled as Tomato Sauce with a date of ,d+[DATE].</p> <p>e. A clear plastic food storage container was labeled Chocolate Frosting with a date of ,d+[DATE].</p> <p>f. A clear plastic food storage container was labeled as Chicken Noodle Soup with a date of ,d+[DATE].</p> <p>g. An unlabeled and undated clear plastic food storage container held a cloudy white/tan colored fluid with food items identified by the Dietary Manager as hot dogs.</p> <p>h. An unlabeled and undated clear plastic food storage container held a thick red substance identified by the Dietary Manager as spaghetti sauce.</p> <p>i. Two open, undated, one-gallon containers of Italian dressing were located on a top metal shelf.</p> <p>j. An open plastic container of coleslaw, dated ,d+[DATE].</p> <p>k. An open clear plastic bag of lettuce wrapped with clear plastic film was undated.</p> <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>I. During an interview on [DATE] at 11:19 AM, the Dietary Manager stated the food was past the 3 days and would have to be thrown away.</p> <p>2. On [DATE] at 11:20 AM, the following observations were made:</p> <p>a. A clear plastic food storage container was labeled as turkey with an open date of ,d+[DATE].</p> <p>b. A sealed clear plastic storage bag contained an open, used plastic dispensing bag of whipped topping with no open date.</p> <p>3. During an observation on [DATE] at 7:20 AM, a cell phone was laying on the silver preparation counter with a bottle of spray hand sanitizer, to the left of the Dietary Manager. The cell phone sounded with music, the dietary manger touched the phone to silence the sound, picked up the hand sanitizer and sprayed left hand, placed sanitizer back on preparation counter, and rubbed hands together. The Dietary Manger continued to place cereal, yogurt, condiments, and beverages on resident trays being passed through the service window to be served to residents. At 7:30 AM the cell phone sounded and was silenced by the Dietary Manager. The cell phone sounded an additional 4 times and was silenced each time by the Dietary Manger. The Dietary Manger used spray sanitizer and continued placing items on resident breakfast trays. At 7:38 AM, the Dietary Manger opened and entered the walk-in refrigerator, obtained three containers of yogurt, returned to the service counter, placed 1 yogurt on a resident tray, two yogurts into a holding bin. No hand hygiene was performed.</p> <p>At 7:45 AM, the Dietary Manager returned to walk in refrigerator and obtained two containers of grape juice, placed on tray and used spray hand sanitizer.</p> <p>4. A facility policy titled, Food Receipt and Storage, dated [DATE], provided by the Dietary Manager on [DATE] at 10:14 AM indicated, . Purpose: Foods should be received and stored properly to prevent food borne illness . ll. Storage of Foods . k. Open food items should be covered, labeled, and dated</p> <p>5. A facility policy titled, Food Preparation Guidelines, dated [DATE], provided by the Dietary Manager on [DATE] at 10:14 AM indicated, . Purpose: To assure that the nutritive value of food is not compromised because of prolonged food storage . Attached is an exhibit . Storage of Refrigerated Foods . cover and label with item name and date . Leftovers discarded after 72 hours (3 days) if not used</p> <p>6. A review of a facility policy titled, Leftover Food Storage and Use, dated [DATE], provided by the Dietary Manager on [DATE] at 10:14 AM indicated, . Purpose: To assure that food borne illnesses are avoided . b. Leftover foods should be covered, labeled and dated . c. Refrigerated leftover foods should be used within 72 hours (three days). If not used within 72 hours, refrigerated foods should be discarded .</p> <p>7. A review of a facility policy titled, Hand-washing Guidelines, dated [DATE], provided by the Dietary Manager on [DATE] at 10:14 AM indicated, To prevent the spread of bacteria that may cause food borne illnesses .Frequency of Handwashing; Hands should be washed in the following situations . After hands have touched anything unsanitary .</p> <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>8. On [DATE] at 4:20 AM, 2 of 2 containers that contained poultry seasoning were on a rack in the kitchen with an expiration date of [DATE].</p> <p>9. On [DATE] at 4:21 AM, a bag of sandwich bread was on the food preparation counter with an expiration date of [DATE].</p> <p>10. On [DATE] at 4:28 PM, the following observations were made in the walk-in refrigerator:</p> <p>a. The temperature of the walk-in refrigerator was 50 degrees Fahrenheit. The surveyor asked the Dietary Manager to check the internal temperature of the milk in a gallon. She did so, and stated, It was 50 degrees. A different temperature gauge was used to check milk, which remained at 50 degrees Fahrenheit. The surveyor asked the Dietary Manager to check a carton of milk and milk from different gallons with an initial temperature gauge. She did and both milks registered to be 40 degrees Fahrenheit.</p> <p>b. An opened box of sausage was on a shelf. The box was not covered or sealed.</p> <p>c. A container of leftover peanut butter dated [DATE] was on a shelf in the refrigerator. The surveyor asked the Dietary Manager how long could the leftover food item be kept in the refrigerator? She stated, We keep it for a week. I don't think it was on the 12th. I think they were trying to put 22, instead of 12.</p> <p>11. On [DATE] at 5:25 PM, Dietary [NAME] (DC) #1 wore gloves on his hands while serving supper. DC #1 picked up tray cards, straws and placed them on the trays, contaminating the gloves. Without changing gloves and washing his hands, DC #1 picked up sandwiches with his contaminated gloved hand and placed them on the plates to be served to the residents.</p> <p>12. On [DATE] at 5:29 PM, the following observations were made in the storage room.</p> <p>a. Nine bags of bread on the bread rack in the storage room with an expiration date of [DATE].</p> <p>b. Two bags of bread with an expiration date of [DATE].</p> <p>c. One bag of hot dog buns with 8 buns in it with an expiration date of [DATE].</p> <p>d. There were 2 bags of corn chips on the rack with an expiration date of [DATE].</p> <p>e. There were 2 -20 boxes of pinto beans with an expiration date of [DATE] and 8 bottles of sauce on a rack with an expiration date of [DATE] Dietary Manager stated, I don't even know why the sauce and pinto bean were still there we never used them.</p> <p>13. On [DATE] at 5:54 PM, DC #1 walked out of the freezer carrying a pan that contained chicken salad sandwiches and placed it on the counter. Without washing his hands, DC #1 placed gloves on his hands, contaminating the gloves. DC #1 then used his gloved hands to pick up chicken salad sandwiches and placed them on the plates and served them to the residents for supper.</p> <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>a. At 6:00 PM, the Surveyor asked DC #1 what he should have done after touching the freezer door and walked out with a pan of chicken salad sandwiches and/or before handling food items. He stated, I should have changed gloves and washed my hands.</p> <p>14. On [DATE] at 5:57 PM, the following observations were made in the freezer.</p> <p>a. There were 3 opened boxes of biscuits on a shelf in the freezer. The boxes were not covered or sealed.</p> <p>b. An opened box of hamburger patties was on a shelf in the freezer. The box was not covered or sealed.</p> <p>c. A partially opened box of vanilla ice cream was on a shelf in the freezer. The ice cream was discolored. The surveyor asked the Dietary Manager to describe the appearance of the ice cream. She stated, It looked like it has been melted and refroze.</p> <p>15. On [DATE] at 6:28 PM, the ice machine panel, which was in contact with the ice before dropping into the ice collector, had wet orange residue on it. The Surveyor asked the Dietary Manager to wipe the panel. She did so, and the residue easily transferred to the paper towel. The Surveyor asked her to describe the substance. She stated, It was orange dirt. The Surveyor asked the Dietary Manager to wipe the inside back panel. She did so, and accumulation of wet black residue easily transferred to the paper towel. The Surveyor asked her to describe the substance. She stated, It was gunk. The Surveyor asked, How often is the ice machine cleaned? She stated, I don't know how often. The housekeeping supervisor cleans it. The Surveyor asked, Does it look like it has been cleaned once a week? She stated, No. The Surveyor asked, Who uses ice from the machine? She stated, They use it to fill beverages served to the residents at mealtimes. That's the ice the CNAs. [Certified Nursing Assistants] use for the water pitchers in the resident 's rooms. On [DATE] at 8:41 AM, the Surveyor asked housekeeping and Laundry Supervisor who was responsible for cleaning the ice machine in the Dining Room. She stated, It has been missed a couple of times. We will in-service them on cleaning ice machine.</p> <p>16. On [DATE] at 6:30 PM, the ice scoop holder on the wall by the ice machine had a wet accumulation of black grayish residue at the bottom of it. The ice scoop was stored in the scoop holder in direct contact with the residue. The surveyor asked the Dietary manager to wipe the black residue at the bottom of the scoop holder. She did so, and the black residue easily transferred to the tissue. The Surveyor asked the Dietary Supervisor to describe the appearance of what was inside the scoop holder. She stated, There is black dirt. That's where the scoop was brushing onto. The Surveyor asked, How often do you clean the scoop holder? She stated, I clean it two times a day.</p> <p>17. On [DATE] at 7:19 AM, a Certified Nursing Assistant (CNA) #8 who was on the tray line assisting with breakfast meal picked up condiments and carton of beverages and placed them on the trays, contaminating her hands. Without washing her hands, she picked up glasses that contained beverages to be served to the residents for the breakfast meal and placed them on the trays.</p> <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>18. On [DATE] at 8:57 AM, the surveyor and Dietary Manager observed the ice machine in front of the nurse's station. The surveyor asked the Dietary Manager to wipe the inside of the ice machine spout. She did so, and an orange residue easily transferred to the paper towel. The Surveyor asked her to describe the substance. She stated, It was orange dirt. The Surveyor asked the Dietary Manager to wipe the inside of the waterspout attached to the ice machine. She did so, and yellow residue easily transferred to the paper towel. The Surveyor asked her to describe the substance. She stated, It was yellow dirt. The Surveyor asked, How often is the ice machine cleaned? She stated, I don't know how often. The maintenance supervisor cleans it. The Surveyor asked, Who uses ice from the machine? She stated, Everybody, residents, and the staff, At 9:21 AM, the surveyor asked the Maintenance Supervisor who is responsible for cleaning the ice machine spout and how often. He stated, I am. I clean it once a month.</p> <p>19. On [DATE] at 11:10 AM, Dietary Aide (DA) #10 picked up a box of dinner rolls from a cart in the storage room and placed it on top of another utility cart, contaminating her hands. DA #10-then pushed the cart into the dish washing room. Without washing her hands, DA #10 picked up dishes from clean racks and placed them on the cart with her fingers inside of them.</p> <p>20. On [DATE] at 11:15 AM Dietary aide (DA) #10 picked up the water hose with her bare hand, used it to spray leftover food from inside of the dishes, contaminating her hands. She placed the dirty dishes in the dirty racks and pushed the racks into the dish washing machine to wash. After the dishes stopped washing, she moved to the clean side of the dishwasher area and picked up clean dishes and placed them on the clean cart to be used in serving lunch meal to the residents. The Surveyor asked her immediately what you should have done after touching dirty objects or before handling clean Equipment? She stated, I should have washed my hands.</p> <p>21. On [DATE] at 11:29 AM, DC #11 wore gloves on her hands when she picked up a box of dinner rolls from a cart in the storage room and placed it on the counter, contaminating the gloves. DC #11 opened the box of dinner rolls. She then used her gloved hands to remove dinner rolls from the box and placed them in a pan to be heated up and served to the residents for lunch. The surveyor asked DC #11 what she should have done after touching dirty objects and before handling food items and clean equipment? She stated, I should have removed gloves and washed my hands.</p> <p>22. On [DATE] at 11:46 AM, DC #11 walked into the kitchen from the storage wearing gloves on her hands carrying a bag of bacon bites and placed it on the counter. She picked up scissors and used cut open bag of bacon bites. Without changing gloves and 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 for lunch meal. The Surveyor immediately stopped DC #11 and asked what she should have done after touching a bag of bacon bites, scissors and before handling clean equipment and/or handling. She stated, I should have changed gloves and washed my hands.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 39316 42016</p> <p>Based on record review, observation and interview the facility failed to ensure staff implemented hand hygiene to prevent the spread of disease and infection for 3 (Residents #39, #20, and #12) of 3 sampled residents, and failed to ensure a resident was not exposed to pests while in their room for 1 resident (Resident #73).</p> <p>The findings are:</p> <p>1. A review of a Face Sheet indicated the facility admitted Resident #39 with diagnoses that included hemiplegia, hemiparesis, and dementia.</p> <p>The annual Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 05/10/2024 revealed Resident #39 had a Staff Assessment for Mental Status (SAMS) score of 2, which indicated the resident moderately impaired for their daily decision making. Skin and ulcer treatments included, pressure relieving device for chair and bed.</p> <p>On 06/25/2024 at 12:57 PM, Certified Nursing Assistant (CNA) #17 touched the top of Resident #20 ' s head with her right bare hand and patted her head. CNA #17 did not perform hand hygiene.</p> <p>On 06/25/2024 at 12:57 PM, CNA #17 served a meal tray from the kitchen window to Resident #39 with bare hands. CNA #17 placed the meal tray onto the table and removed silverware and started cutting up resident ' s meat with a knife and fork. CNA #17 opened the salt and pepper and sprinkled on Resident #39 ' s food.</p> <p>On 06/25/2024 at 12:59 PM, CNA #17 assisted CNA #8 and placed a gait belt around Resident #39 ' s waist. CNA #8 and CNA #17 assisted Resident #39 up with gait belt and placed into a regular chair and pushed resident to the table. CNA #17 went to the kitchen window and continued to touch shirt with bare hands. CNA #17 did not perform hand hygiene.</p> <p>On 06/25/2024 at 1:01 PM, CNA #17 removed a meal tray from the kitchen window and placed it on the table in front of Resident #12. CNA #17 removed food from the meal tray and placed it on the table in front of Resident #12. CNA #17 opened the salt and pepper packets and put salt and pepper on Resident #12 ' s food. CNA #17 removed silverware and put butter on Resident #12 ' s bread. CNA #17 placed a clothes protector on Resident #12. CNA #17 did not perform hand hygiene.</p> <p>On 06/25/2024 at 1:45 PM, during an interview with CNA #17, CNA #17 revealed hand hygiene should be performed during meal service, and between each tray, and hand hygiene was important, so germs are not passed around during meal service. germs, I know better.</p> <p>On 06/27/2024 at 8:30 AM, CNA #12 revealed during an interview hands should be sanitized between each resident meal tray to prevent cross contamination.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER  Fayetteville Health and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE  3100 Old Missouri Rd Fayetteville, AR 72703	
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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 06/27/24 at 12:37 PM, during an interview with the Director of Nursing (DON), the DON revealed hand hygiene should be performed during meal service before, during, and after to ensure germs are not taken from one resident to another.</p> <p>2. A review of the Face Sheet, indicated the facility admitted Resident #73 with diagnoses that included atherosclerotic heart disease and current diagnoses that included atrial fibrillation, vascular dementia, and obstructive and reflux uropathy.</p> <p>The annual MDS with an ARD of 05/29/2024 revealed Resident #73 had a BIMS score of 9, which indicated the resident had moderate cognitive impairment. Resident #71 required supervision/touching assistance with dressing, partial/moderate assistance with personal hygiene, bathing, putting on footwear and had an indwelling catheter.</p> <p>Review of Resident #73's Care Plan(s) revealed the resident a catheter. Interventions included, observe for signs and symptoms of infections . Fragile skin .observe for environmental concerns .</p> <p>During a concurrent observation and interview on 06/25/2024 at 8:59 AM, CNA #18 stated there are 6 flies on Resident #73's blanket, 3 down here (pointed at the bottom area of the bed near footboard) and 4 up there, (pointed to the top of blanket near Resident #73's shoulders). The trash can is full and looks like hot chocolate with a fly on it. (pointed at a brown substance in a drip pattern down the side of bag extending over rim of trash can) Those are flies on the recliner. CNA #18 stated Maintenance is notified by phone or by placing information in the logbook but could not recall if notification was made regarding the flies.</p> <p>During a concurrent observation and interview on 06/26/2024 at 9:44 AM, in room [ROOM NUMBER], Maintenance stated, flies on the floor, bed, and chair were being treated. No additional information was provided.</p> <p>A review of a facility policy titled, Infection Prevention and Control Program Overview, dated 09/14/2020, indicated, .Goals .Identify and correct problems relating to infection prevention &amp; control practices .Provide a safe, sanitary and comfortable environment .</p> <p>A review of a Named Pest Company Customer Service Report with a service date of 04/19/2024 documented, Service-Related Comment .Named Company Large Fly Program serviced . Glue boards checked. Performed interior spot treatment for large flies .glue boards were 75% full.</p> <p>A review of a Named Pest Company Customer Service Report with a service date of 05/30/2024 documented, Service-Related Comment .Inspected and treated selected areas .Named Company Large Fly Program serviced. Glue boards checked. Glue boards were 75% full .Performed interior spot treatment for large flies .</p>		

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<p>F 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 39316</p> <p>Based on record review, observation, and interview the facility failed to provide residents with a safe, functional, sanitary, and comfortable environment to promote dignity and safety.</p> <p>The findings are:</p> <p>On 06/24/2024 at 3:02 PM, the top of bedside table in room [ROOM NUMBER] observed with hard, thick, vinyl ripped and torn, and edges pointed and sharp.</p> <p>On 06/26/2024 at 11:21 AM, a bedside table in room [ROOM NUMBER] was observed placed over the resident 's bed. The vinyl is torn and ripped, exposing pointed and sharp edges. The Maintenance Director revealed during an interview the bedside table had not been reported. The table could not be fixed, and they are usually thrown away. Maintenance verbally described the table as peeling vinyl and pointed, guaranteed to cause injury, and should have been reported.</p> <p>On 06/27/24 8:30 AM, Certified Nursing Assistant (CNA) #12 revealed during an interview that if something needed to be fixed in the facility, they have a book they write in that goes to maintenance, but that she usually tells the maintenance man and keeps after him until it is fixed.</p> <p>On 06/24/2024 at 11:24 AM, Surveyor observations during initial rounds of room [ROOM NUMBER], the gold doorknob was loose, with a gap at the top of the doorknob revealing it had separated from the door. On side B a green armchair is observed with part of the fabric missing on the front of the left arm, wood and brackets are exposed. In the bathroom the outside bowl is covered in a yellow grime substance, the drain hole under the toilet bowl has no cover.</p> <p>On 06/24/2024 at 12:13 PM, Surveyor observed the C Unit Dining Room, on the left-hand wall is a small patch of missing dry wall, the wall itself is observed to be covered in a brown gummy like substance. Above the end table in the corner drywall is missing matching the length of it, a brown substance covers the surface of the end table. The door to the courtyard has a tile missing at the entrance. The refrigerator in the right-hand corner, a dustpan is observed overflowing with trash including cups, juice cartons, and milk cartons. On the back wall two dents are observed, the top dent a patch has been started, paint is peeling in the area, the lower dent has drywall exposed, the electrical outlet has a piece of drywall missing right behind the top part of the plastic, and the wall itself is covered in brown substance throughout it. On the right wall above the air conditioner unit, a corner has drywall missing exposing metal.</p> <p>On 06/24/2024 at 1:30 PM, Surveyor observed in room [ROOM NUMBER], side B, the wall behind the headboard is missing paints, and pieces of drywall, a live spider is observed to be hanging near the bed. The bed is against the wall, large gouges of drywall and paint are missing, and under the bed debris can be seen from the damage observed. The outlet is missing the lower plastic part, the air conditioner is plugged in, and the right side is hanging out of the outlet slightly.</p> <p>(continued on next page)</p>		

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<p>F 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>06/25/2024 at 2:52 PM, during an interview with Maintenance he stated I have a paper log but I do not keep the papers. Then stated Everybody has my number, usually they text me night and day what is needed throughout the building, I am on call 24/7. Maintenance then stated the project they are working on right now is the vents throughout the building with nothing back logged. Maintenance stated they could forward the messages or write them down.</p> <p>On 06/26/2024 at 12:22 PM, during environmental rounds and interview Maintenance stated that in room [ROOM NUMBER], the doorknob was reported Monday, but they Haven't had time to pick it up. Maintenance stated the exposed wood on the armchair was rough, feels course, sharp could be hazardous. Then stated this was not reported to him. Maintenance stated the drain and other issues in the bathroom has not been reported to him and could be fixed easily. When Surveyor asked about the concerns in the dining room, Maintenance stated this was reported to him three weeks ago, but it has not been taken care of as the residents are in here all day. This makes it difficult to repair in here, as they interrupt while I am working. While walking to the next room Maintenance stated he could not come in early or stay late as I work a second job at this time, and it really can burn you out quick with how many repairs are needed in this facility, I am constantly getting pulled from one project to another. Maintenance stated for room [ROOM NUMBER], that the walls or the electrical outlet has not been reported to him, and he stated that this could be hazardous to the resident especially the outlet. He stated that the wall where the bed was up against has deep scratches.</p> <p>A review of the facility policy Federal Rights of Resident/Guest(s) states (i) Safe environment. The facility must provide, (i)1A safe, clean, comfortable, and homelike environment.</p> <p>49689</p>		

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<p>F 0925</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Make sure there is a pest control program to prevent/deal with mice, insects, or other pests.</p> <p>03508</p> <p>Based on observation, record review, and interview the facility failed to maintain an effective pest control program to ensure the kitchen service areas the main dining room were free of pests. This failed practice had the potential to affect all residents who resided in the facility.</p> <p>The findings are:</p> <ol style="list-style-type: none"> <li>1. The following Pest Elimination Invoice dated 4/19/2024 documented, <ul style="list-style-type: none"> <li>. Inspected and treated selected areas. Performed Exterior Rodent Service, Performed Interior Rodent Service and re set traps. Target Pests Mice, Cockroaches, flies' location kitchen.</li> </ul> </li> <li>2. An Invoice dated 5/30/2024 documented, .large fly serviced .Performed Interior spot treatment, for large flies. Performed Exterior fly treatment .Target Pests .Flies. large Equip. Location. Kitchen. Application Method. Stop Location applied. Dining interior, Exterior Area, kitchen area interior, near entry.</li> <li>3. On 06/26/2024 8:25 AM, there were 5 flies in the storage room. The Dietary Manager closes the door between the storage room and the kitchen.</li> <li>4. On 06/26/2024 at 11:58 AM, a fly was at the edge of a plate on the plate warmer. The surveyor showed it to Dietary [NAME] (DC) #11 who shoood it away.</li> <li>5. On 06/26/2024 at 12:02 PM, a fly was crawling at the edge of a pan that contained baked apples.</li> <li>6. On 06/26/2024 12:26 PM, a fly was crawling at the back of a scoop on the counter by the steam table. The surveyor showed it to Dietary [NAME] (DC) #11 and she shoood it away.</li> <li>7. On 06/26/2024 at 1:11 PM, Resident #93 was sitting in a wheelchair in the dining room and was served a lunch tray. Immediately after the tray was served, a fly flew inside the bowl that contained salad. The surveyor immediately showed it to the Certified Nursing Assistant (CNA) #18 who was assisting residents in the dining room. She immediately removed it and brought another bowl of salad to the resident.</li> <li>8. On 06/26/2024 at 1:29 PM, the surveyor observed Dietary [NAME] (DC) #6 enter the kitchen through the storage room door and left the door opened. At 1:30 PM, the surveyors informed DC #6 that the door was not closed when he came into the kitchen through the door. DC #6 was asked by the survey to count the flies that were in the storage room. He stated, We have problems with flies. I counted 8 flies or more. That's a lot of flies. They come in when the door is left open. There is a dumpster close to the kitchen.</li> <li>9. On 06/26/2024 at 1:44 PM, CNA #12 stated, We have a lot of smokers. Fly comes in when they hold the door to let residents out.</li> </ol> <p>(continued on next page)</p>		

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<p>F 0925</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>10. An Invoice dated 06/26/2024 documented, Inspected and treated selected areas. Performed Exterior and interior fly treatment, placed 2 bags on building exterior, added fly light dining area, added baited fly panels to kitchen.</p>		