STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045236	A. Building B. Wing	01/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Des Arc Nursing and Rehabilitation Center	2216 West Main Street Des Arc, AR 72040

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 50682 Based on observation, interviews, and record review, it was determined that the facility failed to ensure dignity was maintained for 1 (Resident #10) of 1 sampled resident reviewed for dignity while passing meal trays. Finding included: 1.Review of a facility policy titled Resident Rights and Responsibilities with no date indicated, The facility protects and promotes the rights of each resident admitted in order to provide a dignified existence. Review of an Admission Record indicated the facility admitted Resident # 10 on 12/14/2012, with diagnoses of bipolar disorder and generalized anxiety disorder. The annual Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 01/06/2025, revealed Resident #10 had a Brief Interview for Mental Status (BIMS) score of 12, which indicated Resident #10 was moderately cognitively impaired. On 01/15/2025 at 7:39 AM this surveyor observed Certified Nursing Assistant (CNA) #1 serving meal trays to the residents in the dining room. CNA #1 served all the residents in the dining room except Resident #10. CNA #1 left the dining room without serving Resident #10 a breakfast tray. Resident #10 yelled out to CNA #1 that the resident wanted a meal tray. CNA #1 stopped and provided him with his meal tray. Resident #10 was interviewed on 01/15/2025 at 7:45AM. Resident #10 stated that it was not right for the CNA to leave the dining room without passing all trays. On 01/15/2025 at 8:00 AM, CNA #1 was asked if all trays should have been served before leaving the dining room. She stated Resident #10's tray should have been served before leaving the dining room to pass other trays. On 01/15/2025 at 8:30 AM, Licensed Practical Nurse (LPN) #5 was asked if all trays should have been served before leaving the dining room. She stated she should have served Resident #10's tray before leaving the dining room to pass other trays. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045236	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/16/2025
NAME OF PROVIDER OR SUPPLIER Des Arc Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2216 West Main Street Des Arc, AR 72040	

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 01/15/2025 at 3:00 PM, the Director of Nursing (DON) was interviewed and asked if CNA #1 should have served all the trays before leaving the dining room. The DON stated that CNA #1 should have served Resident #10's tray before leaving the dining room to pass other trays.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Reasonably accommodate the needs and preferences of each resident. 50505 50682 Based on observation, record review and interview, the facility failed to ensure call lights were placed in reach for resident's use and failed to ensure residents with functional limited range of motion call lights were placed in reach and accessible for use for 3 (Resident #27, Resident #35, and Resident #270) of 59 sampled residents. The findings are: 1. Review of the of Resident #27 ' s Admission Record reveal diagnoses of Alzheimer's disease and severe dementia with agitation. a. The admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 11/20/2024, indicated the resident had a Brief Interview for Mental Status (BIMS) of 00 which indicated severely impaired cognitive skills. b. On 01/13/2025 at 2:21PM this surveyor observed Resident #27 in bed. The call light was at the foot of the bed along the side of the wall. Resident #27 could not reach it. c. On 01/13/25 at 2:30 PM, Resident #27 was observed lying in bed with eyes closed. The call light was at the bottom of the bed along the side of the wall. The call light was not within reach of the resident. d. On 01/13/25 3:31 PM, Resident #27 was observed with the call light to be in the same location at the bottom of the bed along the side of the wall. The call light was not within reach of the resident. e. On 01/13/25 3:38 PM, during an interview, Certified Nursing Assistant (CNA) #1 was asked if the call light was in reach of Resident #27. CNA #1 confirmed the call light was not in Resident #27's reach, but it should have been. 2. Review of Resident #35 ' s Admission Record revealed diagnoses of severe dementia with agitation and anxiety disorder. f. The admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 11/01/24 indicated Resident #35 had a Brief Interview for Mental Status (BIMS) 00 which indicated the resident had impaired cognitive skills. g. On 01/13/25 at 2:32 PM, Resident #35 was observed lying in bed with eyes closed. The call light was located along the wall at the end of the resident's bed. The call light was not within the reach of the resident. h. On 01/13/25 at 3:39 PM, this surveyor observed CNA #2 reach back behind Resident 35's bed, pull the call light cord up, and clipped the cord on the blanket next to the resident. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER: Des Arc Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 2216 West Main Street Des Arc, AR 72040	

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	i. On 01/13/2025 at 4:00 PM, during an interview, Licensed Practical Nurse (LPN) #5 stated the call light should be placed within the resident's reach at all times. j. On 01/14/2025 at 9:00 AM, during an interview, the Director of Nursing (DON) stated the call light should always be placed within the resident's reach. k. On 01/16/2025, The DON stated there was no policy on placement of call lights. 3) A review of the Admission Record, indicated the facility admitted Resident #270 with diagnoses that included chronic obstructive pulmonary disease, acute and chronic respiratory failure, dysphagia, cognitive communication deficit, the need for assistance with personal care and quadriplegia. a. The quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 11/14/2024, revealed Resident #270 had a Brief Interview for Mental Status (BIMS) score of 14 which indicated the resident was cognitively intact and had an impairment to one of the upper extremities and impairment to bilateral lower extremities. Resident #270 was using oxygen therapy and had non-invasive mechanical ventilator use. b. Review of Resident #270's Care Plan, initiated on 02/13/2024, revealed Resident #270's usual performance was weight bearing assist with Activities of Daily Living (ADL's). Interventions included: one (1) staff member to assist with bed mobility and Resident #270 used grab assist rails on bed for bed mobility. There was no indication in the current care plan of Resident #270's ability to use the call light. c. During an observation on 01/13/2024 at 11:35 AM, upon entering Resident #270's room, a therapist was noted to be leaving the room. Resident #270 was lying in bed with oxygen being delivered at four (4) liters per minute via nasal cannula. The call light for Resident #270's use was observed to be behind the lamp sitting on the nightstand and not within reach of Resident #270. d. During a concurrent observation and interview on 01/13/2024 at 11:37 AM, Registered Nurse (RN) #3 was asked to come into Resident #270's room and give the call light to the resident. RN #3 looked around and was unable to locate the call light button. This surveyor told RN #3 where the call light could be found. RN #3 then placed the call light in Resident #270's hand. RN #3 confirmed that the call light was not within reach of the resident while it was behind the lamp on the nightstand. e. During an interview on 01/14/25 at 10:00 AM, the Rehab Director was asked if the call light had been placed within reach of Resident #270 before leaving the room on 01/13/2025 at 11:35 AM. The Rehab Director stated, Yes, she had the little beige box in her hand. When it was explained that box was not the call light, but the bed control and that the call light was behind Resident #270's lamp and nightstand, the Rehab Director stated, I'm sorry, I thought it was the call light.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50505 Based on interviews, record review, facility document review, and facility policy review, it was determined that the facility failed to ensure Advance Directives were up to date in the electronic medical record (EMR) for 1 (Resident #24) of 1 resident reviewed for Advance Directives. The findings include: A review of the facility's undated policy titled Advance Directives, indicated that revocation will be documented in the resident's plan of care and/or the medical record. A review of the Admission Record, indicated the facility admitted Resident #24 with diagnoses that included hemiplegia and hemiparesis following cerebral infarction and post-traumatic stress disorder. The quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of [DATE], revealed Resident #24 had a Brief Interview for Mental Status (BIMS) score of 0, which indicated the resident had severe cognitive impairment. A review of Resident #24's Care Plan, initiated on [DATE], revealed the resident had requested that no cardiopulmonary resuscitation (CPR) measures be performed and a code status of Do Not Resuscitate (DNR). Interventions included: communicate choice to all appropriate staff members and to follow the DNR instructions as detailed inside the Advance Directive &/or living will. A review of an Order Summary Report revealed Resident #24 had orders to: Admit to Palliative Care and DNR. A review of the Miscellaneous tab in the electronic medical record revealed Resident #24 had an advance directive dated [DATE], which was marked yes for CPR, life support/other artificial support, treatment of new conditions and tube feeding/intravenous fluids (IV). A review of the new Advance Directive Acknowledgement, signed and dated [DATE], supplied by the Director of Nursing (DON) on [DATE], indicated Resident #24 was a DNR and wished not to execute an Advance Directive. A review of a note from the Advanced Practiced Registered Nurse (APRN), dated [DATE], stated that Resident #24's wife wished to go with Palliative Care and that Resident #24 would not want CPR. The APRN's summary of the treatment plan based on the discussion with Resident #24's wife was that the resident would be changed to DNR status when the wife was available to sign papers and Resident #24 would admit to Palliative Care to be done by the facility. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on [DATE] at 11:33 AM, Medical Records stated the Advance Directive dated [DATE], had not been scanned into the Electronic Medical Record, but that it would be. Medical Records reported an audit had been completed and it was found at that time. Medical Records responded that the nursing staff would have been trained on what paperwork would be needed if a resident was sent out to the hospital. During an interview on [DATE] at 11:40 AM, Registered Nurse (RN) 3, explained the process for sending someone to the hospital and what paperwork had to be sent. RN #3 reported that the Admission Record, order summary report and the Advance Directive/Code Status would be sent. During an interview on [DATE] at 11:50 AM, the DON confirmed that the paperwork that would be sent with a resident transferring to the hospital from the facility would include the face sheet, order, Emergency Medical Services (EMS)/DNR order and the Advance Directive, if the resident had one. The DON agreed that the most current Advance Directive dated [DATE], was scanned into the EMR on [DATE].

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. 38200 Based on record review, interviews, facility document review, it was determined that the facility failed to complete an accurate Minimum Data Set (MDS) for 1 (Resident #7) of 8 sample mix residents reviewed for MDS accuracy. The findings are: Review of Resident #7's Administration Record dated 05/2/2022, noted a diagnosis of Stroke (Cerebral Infarction). Review of Resident #7s Care Plan with a date of 07/11/2022, noted Resident #7 on prevention for blood clots from forming (antiplatelet) therapy related to stroke. Administer blood thinner (anticoagulant) medications as ordered by physician. Review of Resident #7's quarterly MDS with an Assessment Reference Date (ARD) of 12/12/2024, noted on Section N0415- High- Risk Drug Classes: Use and Indication, E. Anticoagulant: Yes. Review of Resident #7's Order Summary Report dated 01/14/2025, noted [Medication used to help prevent blood clots] tablet chewable 81 milligrams (MG) give 1 tablet by mouth one time a day for stroke (CVA), with a start date of 03/24/2023. Review of Resident #7's Order Summary Report Active, Completed, Discontinued, On Hold, dated 01/14/2025, noted the resident had not received an anticoagulant. During an interview with the MDS Coordinator on 01/16/2025 at 1:52 PM, she confirmed Resident #7 does not receive an anticoagulant, had not received one in the past and the MDS should have been coded for an antiplatelet.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 38200 51477 Based on interviews, record review, facility document review, and facility policy review, it was determined that the facility failed to ensure the comprehensive care plan addressed and individualized appropriate care and services for 3 (Resident #20, # 37, 30) of 14 sample mix residents reviewed for care plans. The findings are: Review of Resident #37's Admission Record dated 10/07/2024, noted diagnoses for hypothyroidism, type 2 diabetes mellitus, chronic heart failure, schizophrenia, pain, depressive episodes, pain in joints, heart attack (myocardial infarction), and atrial fibrillation (A-Fib). Review of Resident #37's Care plan dated 10/7/2024, did not note medication names or black box warnings. Review of Resident #37's Order Summary Report with a date of 1/15/2025, noted [Name brand thyroid medication] oral tablet 75 micrograms (MCG) give 75 mcg by mouth in the morning related to low thyroid (hypothyroidism); [Name brand glucagon-like peptide-1 receptor agonist medication] (1 milligram (MG) per dose) subcutaneous solution pen-injector 4 MG per 3 (milliliter (ML) inject 2 mg subcutaneously one time a day every Thu related to Type 2 Diabetes; [Name brand diuretic] oral tablet 80 MG give 1 tablet by mouth two times a day related to Chronic Heart Failure; [Name brand angiotensin receptor neprilysin inhibitor medication]oral tablet 24-26 MG give 1 tablet by mouth two times a day related to Chronic Heart Failure;[Name brand atypical antipsychotic medication] oral tablet 10 MG give 10 mg by mouth one time a day related to Schizophrenia; [Name brand combination opioid pain medication]oral tablet 10-325 MG give 0. 5 tablet by mouth at bedtime related to pain; [Name brand selective serotonin reuptake inhibitor medication]oral tablet 10 MG give 1 tablet by mouth one time a day related to Depressive episodes; [Brand name medication used to treat depression] oral tablet 100 MG give 1 tablet by mouth at bedtime related to Depressive episodes; [Brand name opioid agonist used to treat chronic pain] Oral Tablet 50 MG Give 1 tablet by mouth every 6 hours as needed for pain related to pain in joint; [Brand name anticoagulant] oral tablet 75 MG give 1 tablet by mouth one time a day related to Myocardial Infarction; [Brand name medication used to treat heart dysrhythmias] oral tablet 200 MG give 1 tablet by mouth one time a day related to Atrial Fibrillation; -[Brand name fast acting insulin] injection solution 100 unit per ML inject as per sliding scale starting at 200 subcutaneously two times a day related to Type 2 Diabetes. Review of Resident #30's Admission Record dated 1/31/2024, noted diagnoses of chronic pain, history of blood clot in the deep vein and artery blockage (venous thrombosis and embolism), and mild neurocognitive disorder due to known physiological condition with behavioral disturbance. Review of Resident #30's Care Plan dated 8/16/2024 did not note medication names or black box warnings. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #30's Order Summary Report dated 1/16/2025, noted [Name brand anti-depressant medication] oral tablet 100 MG Give 100 mg by mouth one time a day related to Depression; [Brand name narcotic pain medication] tablet 300-30 MG Give 0.5 tablet by mouth three times a day related to Chronic Pain; [Brand name medication used to treat deep vein thrombosis]oral tablet 5 MG give 5 mg by mouth two times a day related to History of venous thrombosis and embolism; [Brand name anti-psychotic medication] oral tablet 0.5 MG give 0.5 mg by mouth two times a day related to Psychosis not due to a substance or known physiological condition. Review of an Admission Record indicated that the facility admitted Resident #20 with a diagnosis of paraplegia. The admission/ 5-day Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 11/22/2024, revealed Resident #20 had a Brief Interview for Mental Status (BIMS) score of 10 which indicated the resident had moderate cognitive impairment. Review of Resident #20 ' s Care Plan revealed, that it did not have any therapy, nor black box warnings listed within the care plan. During an interview on 01/15/2025 at 10:39 AM, the MDS Coordinator reported that black box warnings alert an individual of certain medications and what to look out for. The MDS Coordinator stated, From what I understand, no, we don't care plan black box warnings. During an interview on 01/15/2025 at 10:57 AM, the DON (Director of Nursing) revealed that black box warnings were not in care plan and should be added to the care plan. During an interview on 01/16/2025 10:14 AM, the MDS Coordinator revealed Resident #20 came off therapy on the 14th of this month. The MDS Coordinator stated, therapy was not in care plan and that there are orders for therapy that need to be discontinued.

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. 50505 Based on observations, interviews, and facility document review, it was determined that the facility failed to ensure mechanical soft food was ground to the right consistency to meet the needs of residents who required a mechanical soft diet during one (1) of one (1) meal service observed. The failed practice had the potential to affect eight (8) residents who required mechanical soft diets. The findings include: On 11/15/2025 at 7:36 AM, the Dietary Manager stated the facility did not have a policy for mechanically altered foods. On 11/14/2025 at 11:07 AM, [NAME] #4 stated the facility had 3 pureed and 8 mechanical soft diets and 2 regular diets who requested mechanical soft meat. After gathering supplies needed to begin preparing for mechanical soft, [NAME] #4 began by using the processor machine and added 10 pork chops to process into mechanical soft. After completing the blending process, [NAME] #4 poured the mechanically altered pork chops into a pan, covered the pan with aluminum foil, and placed on the steam table. During a concurrent observation and interview, on 11/14/2025 at 12:10 PM with [NAME] #4, the mechanically altered pork chop was at 157.8 degrees Fahrenheit temperature. [NAME] #4 was asked what the consistency was for the mechanical pork chop. [NAME] #4 responded, pork chops always have looked that way and [NAME] #4 stated it does appear to look like a thick paste. The Dietary Manager, at that time, came over to the steam table and was asked to describe the pork chops. The Dietary Manager stated, looks a little thick, and the Dietary Manager confirmed that the mechanically altered pork chops had a paste consistency. The Dietary Manager asked cook #4 if the processor machine had been pulsated and cook #4 replied, I just hit the green button. The Dietary Manager explained to [NAME] #4 that the green button was to be pushed, stopped, pushed and stopped again to pulsate. The Dietary Manager agreed that the thick paste-like mechanically altered pork chop could cause an issue with swallowing.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 50505 Based on observations, interviews, record review, facility document review, and facility policy review, it was determined that the facility failed to ensure the internal components of the ice machine were cleaned and the container for storing the ice scoop were cleaned when reviewed for safety and infection control to prevent waterborne illnesses. Findings include: On 01/16/2025 at 8:20 AM, the Administrator stated the facility did not have a policy for the ice machine. During an observation on 01/16/2025 at 8:00 AM, the Dietary Manager used a napkin to go around the edges inside the ice machine. Inside the ice machine was a metal border on the top portion of the machine. After wiping the metal plate, a black residue was noted to be on the napkin. After completing the ice machine, the ice scoop drawer was removed and inside the drawer was a pink/beige residue in the corners around the drawer. On 01/16/2025 at 8:05 AM, the Dietary Manager reported that the Maintenance Supervisor was responsible for cleaning the ice machine, and that the Dietary Department was responsible for washing the scoop holder. A review of the Ice Machine Cleaning Log on 01/16/2025, indicated that the ice machine had been wiped down to ensure there was no build up on the ice machine, and the hopper had been emptied out, and disinfected on 01/14/2025. During an interview on 01/16/2025 at 8:30 AM, the Dietary Manager confirmed that it was important for the ice machine to be cleaned because it could cause harm and make someone sick. The Dietary Manager then stated, we are going to shut it down and clean it. The Dietary Manager reported that the scoop drawer was on a cleaning schedule, but that there was no log for the cleaning to be recorded. During an interview on 01/16/2025 at 1:04 PM, the Maintenance Supervisor stated the ice machine was digital, and lets the facility know when it is time for it to be cleaned. The Maintenance Supervisor reported that even if the light was not on to indicate the ice machine needed cleaning, the ice machine was cleaned every two (2) weeks or monthly. The Maintenance Supervisor confirmed that the ice machine was descaled, and the ice machine hopper was emptied out every 2 weeks or as needed.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 50505 50682 51477 Based on observations, interviews, record review, and facility policy review, it was determined that the facility failed to ensure infection control processes are maintained for 2 (Resident #8 and #270) residents of 3 residents reviewed for improper handling of eating utensils and not being under contact isolation for communicable disease. Finding included: Review of a facility undated policy titled, PP Infection Control, indicated, The facility will establish and maintain an infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. A review of a facility policy titled, Transmission-Based (Isolation) Precautions, dated 2022, indicated, for a resident who is immuno-compromised; should be on contact isolation for herpes zoster (shingles). Review of the Admission Record, indicated the facility admitted Resident #270 with diagnoses that included: chronic obstructive pulmonary disease, acute and chronic respiratory failure; malnutrition, myocardial infarction, iron deficiency anemia, thrombocytosis and the presence of a cerebrospinal fluid drainage device. Review of a quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 11/14/2024, revealed Resident #270 had a Brief Interview for Mental Status (BIMS) score of 14, which indicated the resident was cognitively intact. A review of Resident #270's Care Plan, initiated on 01/10/2025, revealed the resident required enhanced barrier precautions related to indwelling medical device (feeding tube). Interventions included: was to wear disposable gloves and gowns when providing high contact care. Resident #270 had a Care Plan initiated 01/09/2025, for a yeast rash in between and to the right finger. Interventions included: to avoid scratching and keep hands and body parts from excessive moisture, evaluate rash weekly with skin audit, give antiviral medication as ordered. Observe for any adverse reactions. Notify medical doctor as needed and observe skin rashes for increased spread or signs of infection. A review of the Order Summary Report, revealed Resident #270 had enhanced barrier precautions related to feeding tube and an order for valacyclovir hydrochloride 1000 milligrams (mg) by mouth every eight (8) hours for rash to the right arm. A review of Medication Administration Record (MAR), revealed Resident #270 had been receiving enhanced barrier precautions since 01/10/2025. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045236	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/16/2025
NAME OF PROVIDER OR SUPPLIER Des Arc Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2216 West Main Street Des Arc, AR 72040	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the Infection Screening Evaluation completed 01/15/2025 at 11:09 AM, revealed Resident #270 had the symptom: vesicular rash. A review of the Skilled Note A Every 8 hours, dated 01/13/2025, revealed no documented rash or skin issue. A review of the Advanced Practice Registered Nurse (APRN) progress note dated 01/13/2025, revealed that Resident #270 had a new rash to right arm with small vesicles present. APRN observed erythematous, warm rash to inner aspect of right arm extending to fingers on right hand with small, closed blisters noted throughout the rash. Per the APRN note, Resident #270 denied itching but stated that the area was burning. The Assessment/Plan per the APRN included: 1. Herpes Zoster-acute, start valacyclovir 1000mg every 8 hours for 7 days. To keep the area clean and dry. To Keep area covered if blisters rupture/open. Isolation precautions as necessary. Notify the provider of any acute concerns. During an interview on 01/15/2025 at 1:28 PM, Director of Nursing (DON), stated the order for the Valacyclovir (antiviral) was written on 01/13/2025 at 11:00 PM. DON stated that the rash was noted by the certified nursing assistants who then went to the nurse and then the nurses went to assess the rash. DON was asked to review the nurse's notes and confirmed there was only a note stating that the medication had started. DON stated that the APRN had seen the resident that day (01/13/2024) and it was just uploaded into the electronic medical record on 01/15/2025. DON stated the resident had not been placed on isolation because the blisters were not ruptured and because Resident #270 had intact skin. DON stated that on 01/13/2025, per nursing documentation, there were no nurses notes that mentioned any skin issues. When asked if there was any antibiotic stewardship follow up on the infection, DON replied, it did not require antibiotic stewardship due to it being an antiviral medication. On 01/15/2025 at 7:39 AM, CNA #1 was assisting Resident #8 on the male unit with meal set up. Without washing her hands, after touching trays and opening containers, she picked up a fork by the tines (the end of the fork that goes into the mouth) and handed it to Resident #8. On 01/15/2025 at 8:45 AM, CNA #1 was asked if she should have picked the fork up by the tines and she stated, No, I should have handed it to him by the handle and washed my hands. On 01/16/2025 at 9:00 AM, the DON was asked if the CNA should have handled the fork by the tine, and stated she should have handed it to the resident by the handle.