

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045246	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/05/2024
NAME OF PROVIDER OR SUPPLIER Perry County Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1321 Scenic Drive Perryville, AR 72126	

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 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>49413</p> <p>Based on observation, interview, and record review, the facility failed to ensure residents on the Dementia Unit were supervised at all times to prevent accidents and hazards for 1 (Resident #50) sampled resident.</p> <p>Findings are:</p> <p>On 9/3/2024 at 12:18 PM, Resident #50 was in the Observation Hall (a locked unit for residents with dementia) Dining Room sitting in a mobility device. Resident #50 self-propelled up to the trash can, located along the outside wall, lifted the lid and reached in with both hands. Resident #50 closed the lid and self-propelled out of the dining room. Staff was not in dining room during this time.</p> <p>On 9/3/2024 at 12:58 PM, Certified Nursing Assistant (CNA) #4 left seven dementia residents to eat in the Observation Hall Dining Room unattended (drink and meals were in front of residents). CNA #4 went to get an alternative meal for a resident. CNA #4 was gone from the dining room between 12:58 PM to 1:06 PM.</p> <p>On 9/5/2024 at 8:45 AM, CNA #4 stated it was unsanitary for Resident #50 to place both arms in the trash bin. You don't want the resident to pick anything up from inside the trash can and place the item in their mouth. CNA #4 confirmed there should always be an employee in the Observation Hall Dining Room in case a resident choked or needed something, fell or became combative or needed redirection.</p> <p>On 09/05/24 at 08:53 AM, Licensed Practicing Nurse (LPN) #5 confirmed Resident #50 arms should not be inside the trash can; it was not sanitary, and there is a concern of an item placed in the residents' mouth. There should always be a staff member in the Observation Hall Dining Room, during mealtimes, for resident safety due to choking hazards or behaviors.</p> <p>On 9/05/24 at 8:56 AM, the Director of Nursing (DON) confirmed there was a concern of infection control and safety of Resident #50 putting their arms inside the trash can. There should be staff in the Observation Hall Dining Room during mealtime, to ensure no one choked, and or had an altercation or fell .</p> <p>The Facility did not have an Observation Hall Dining Room policy/procedure.</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0803</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - 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 ensure that nutritionally balanced meals were provided for the residents for 1 of 1 meal observed.</p> <p>The findings are.</p> <ol style="list-style-type: none"> On 9/3/24 the noon meal menu indicated all residents on mechanical soft diets were to receive 2 ounces of gravy and for pureed diets, 2 ounces of gravy and one #10 (equivalent to 3 ounces) scoop of pureed bread. On 9/3/24 at 12:23 PM, the residents on pureed diets were not served cornbread or regular bread. There were no substitutes served to the residents in place of bread. On 9/3/24 at 12:50 PM, the residents on mechanical soft diets were not served gravy. On 9/3/2024 at 1:06 PM, during an interview Dietary [NAME] (DC) #1 was asked about the texture of the pureed bread prepared to serve to the residents on pureed diets. DC #1 stated it looked like a dough ball when prepared, so it was not served to the residents. DC #1 confirmed she made gravy but forgot to serve it.

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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 observations, record review, interview, and review of the facility policy, 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 1 of 1 meal observed.</p> <p>The findings are:</p> <ol style="list-style-type: none"> On 9/03/24 at 11:50 AM, Dietary [NAME] (DC) #3 placed 6 servings of breaded fried pork chops into a blender, added a carton of whole milk and pureed. At 11:52 AM, DC #3 scraped pureed pork chops into a pan, covered the pan with foil and placed it in the oven. The consistency of the pureed fried chops was more of a ground texture and thick. On 9/3/24 at 11:09 AM, DC #3 used a #8 scoop (1/2 cup) to portion 6 servings of turnip greens into a blender and pureed. At 11:11 AM, DC #3 poured the pureed greens into a pan, covered the pan with foil and placed it in the oven. The consistency of the pureed turnip greens was thick. On 9/3/24 at 11:23 AM, DC #3 used a #8 scoop to portion 6 servings of black-eyed peas into a blender, added a carton of whole milk and pureed. At 11:25 AM, DC #3 scraped the pureed black-eyed peas into a pan, covered the pan with foil and placed it in the oven. The consistency was lumpy and thick. On 9/3/24 at 12:58 PM, the Dietary Manager stated pureed meat had consistency of ground meat and was too thick. They did not put gravy on it. On 9/3/24 at 1:04 PM, DC #3 who prepared the pureed food items stated the pureed turnip greens, pureed black-eyed peas and pureed fried pork chops were too dry. They were dry when I put them in the oven. I used a carton of milk when I pureed the pork chops and peas. On 9/3/24 at 12:10 PM, the consistency of the pureed turnip greens remained as thick as it was when first pureed and placed in the oven and when taken out of the oven and placed on the steam table. Pureed black-eyed peas and pureed fried pork chops remained as thick and lumpy as they were when first pureed and placed in the oven and when taken out of the oven and placed on the steam table. This consistency persisted when they were served to the residents. A review of a facility policy titled, Therapeutic and Modified Diets, initiated 8/24/20 and provided by the Dietary Manager on 9/4/2024, indicated to make sure residents received foods with the appropriate texture.

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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>03508</p> <p>Based on observations, record review, interview, and review of the facility policy, the facility failed to ensure employees washed their hands between handling dirty equipment and clean equipment, food items stored on the freezer were covered or sealed to prevent the potential for foodborne illnesses, and hot food items were maintained of 135 degrees Fahrenheit or above on the steam table while awaiting service to prevent potential food borne illness for residents who received meals from 1 of 1 kitchen.</p> <p>The findings are:</p> <ol style="list-style-type: none"> 1. On 9/3/24 at 9:20 AM, Dietary [NAME] (DC) #1 removed a bottle of coke and a glass containing coke from the counter and placed them on the window bar, contaminating her hands. DC #1 removed her gloves from the glove box and placed them on her hands, contaminating the gloves in the process. Without changing gloves and washing her hands. DC #1 then picked up a cucumber from the counter and peeled it. The cucumber slices were placed on top of the salad to be served to the residents who requested salad with their meals. 2. On 9/3/24 at 9:35 AM, the following observations were made on a shelf in the walk-in freezer: <ol style="list-style-type: none"> a. An opened box of biscuits, the box was not closed. b. An opened box of cheddar biscuits, the box was not closed. c. An opened box of sausage links, the box was not covered or sealed. d. An opened box of lima beans, the box was not covered or sealed. e. An open box of beef fritters, the box was not covered or sealed. f. An opened box of cookie dough, the box was not covered or sealed. <p>Dietary Aide (DA) #2 was asked what would happen if food items were not completely covered or sealed. DA #2 stated it will cause freezer burn.</p> <ol style="list-style-type: none"> 3. On 9/3/24 at 11:45 AM, DC #3 wore gloves on her hands when she picked up a spray bottle and sprayed inside a pan, contaminating her hands. Without changing gloves and washing her hands, she picked up a clean blade and attached it to the base of the blender. DC #3 was asked what she should have done after touching dirty objects and before handling clean equipment. DC #3 stated, I should have removed gloves and washed my hands. 4. On 9/03/24 at 12:10 PM, DC #1 checked the temperatures of the hot food items that had been placed on the serving line on the steam table in preparation for the noon meal service. The temperatures were: <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. Pureed pork chops - 120 degrees Fahrenheit.</p> <p>b. Ground pork chops - 119 degrees Fahrenheit.</p> <p>c. Fortified mashed potatoes - 119 degrees Fahrenheit.</p> <p>DC #1 stated it's stopping at 119 degrees Fahrenheit. The above food items were not reheated when served to the residents.</p> <p>6. A review of a facility policy titled, Handwashing and Glove Usage in Food Service, not dated, and provided by the Dietary Manager on 9/3/2024, indicated, hands must be washed before starting work and when engaging in any activities that may contaminate hands.</p>