STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045271	A. Building B. Wing	09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oak Ridge Health and Rehabilitation	501 Hudson St El Dorado, AR 71730

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 47916 Based on observation, and interview it was determined that the facility failed to ensure the tub room door on the Memory Unit was locked to ensure vulnerable residents were free from accidents and injuries, affecting 5 (Resident #25, #41, #56, #61, and #73) sampled residents. Findings include: A review of a policy titled Secure Neighborhood Policy & Procedure Manual, revealed that doors to the exits, janitor closets, mechanical rooms, and shower rooms will not be left unlocked, disengaged, or propped open. On 09/23/24 at 11:21 AM, the tub room door across from the nurse's station in the Memory Unit was observed ajar with one resident considered an elopement risk wandering the hallway. Licensed Practical Nurse (LPN) #1 accompanied the surveyor to the tub room door, and LPN #1 revealed dirty linens are stored in the tub room, and stated the door is supposed to be locked to keep the residents out, because a resident could fall in the tub, or otherwise get hurt in the tub room. During an interview with Director of Nursing (DON), she revealed the process for maintaining the tub and shower rooms were to keep them clean, and locked so that residents do not have access. The DON confirmed there are dirty linens stored in the tub room that residents should not be touching, and if the door shuts residents may not be able to get out, they could fall in the floor or the tub and harm themselves.

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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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. 49596 Based on observation, record review and interview, the facility failed to ensure menus were prepared and followed for 1 of 2 meals observed. The findings are: On 9/24/24 at 1:10 PM, the menu for the noon meal was barbeque beef tips, baked potato salad, fried okra, Texas toast and ice cream. The surveyor observed the meal service of the noon meal. The [NAME] reported the kitchen had run out of barbeque beef tips before all residents were served the lunch meal. The last 4 meal trays prepared from the food line were served chicken nuggets. The Surveyor interviewed Resident #76, who was served chicken nuggets instead of the beef tips indicated on the menu, and the resident said they would rather have had the barbeque beef. The Dietary Manager said she did not know how they ran out of beef tips because they prepared the same number of beef packages as always. On 9/24/24 at 1:45 PM, the surveyor asked the [NAME] why is it important to ensure you have enough food prepared to serve all residents the planned meal. The [NAME] said residents are supposed to get what is on the menu, as this is their home. The [NAME] said he did not know what why they ran out of food because he had prepared the same amount of food he always did.

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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 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. 47916 49596 Based on observations, record review, and interview, the facility failed to store, prepare, distribute and serve food in accordance with professional standards for food service safety. The finding are: On 9/23/24 at 10:16 AM, and again on 9/24/24 at 10:15 AM, a half-cut watermelon dated 9/18/24 was observed stored on the top shelf of the refrigerator. On 09/23/24 at 10:18 AM, the surveyor observed two boxes of ice cream that were not dated. The Dietary Manager (DM) dated the boxes and said they were for activity. On 09/24/24 at 10:15 AM, the surveyor observed eggs stored on the 2nd shelf of the refrigerator with a large bin of prepared potato salad sitting below the eggs. The Dietary Consultant (DC) moved the eggs to the bottom shelf and stated they should not be stored on that shelf but should be stored on the bottom shelf. On 9/25/24 at 9:50 AM, the DM informed the surveyor the eggs were regular eggs and were used for baking. On 9/23/24 at 10:20 AM, the surveyor observed a freezer bag of frozen waffles sitting on the shelf in the freezer were not sealed, leaving the waffles exposed. On 9/23/24 at 10:21 AM, and again on 9/23/24 at 11:47 AM, the surveyor observed 9 bowls of prepared dry cereal were sitting on the pantry shelf not sealed. On 9/23/24 at 10:22 AM, the surveyor observed a large bin of sugar sitting in the pantry with the bin lid not secured to the container, leaving the sugar exposed. On 9/23/24 at 10:22 AM, and again at 11:35 AM, the surveyor observed a dented can of evaporated milk sitting on the shelf in the pantry that was used to store food intended to be served to the residents. On 9/23/24 at 10:45 AM, the surveyor and DM checked the ice machine. The DM wiped the top of the inside of the ice machine with a white napkin. A black substance came off on the white napkin. The DM stated the substance was mold. A sign on the right side of the ice machine indicated the ice machine had been cleaned on 8/20/24. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 09/23/24 at 12:41 PM, Certified Nurse Assistant (CNA) #3 was observed serving a cup of orange drink in the unit dining room to Resident #61 with 2 fingers resting on the rim of the cup and the right palm was resting over the fluid. CNA #3 stated she has not been told a process for serving residents but confirmed she probably should have held the cup from the bottom sides to prevent the resident from drinking where her fingers had been, because it put the resident at risk for cross contamination. On 9/24/24 at 11:04 AM, the [NAME] conducted a sanitization test of the 3-compartment sink with the Parts Per Million specific disinfectant strip, then took bread from the meal prep area and began to prepare peanut butter and jelly sandwiches holding the bread slices with his bare hands. The [NAME] did not wash his hands between the task of testing the sanitizer in the sink and preparing the bread with peanut butter. The [NAME] then went to the pantry area and brought back a container of jelly. The [NAME] did not wash his hands. The [NAME] picked up the bread slices with his bare hands and began to spread the jelly on the bread. The surveyor interviewed the [NAME] and asked him if he had washed his hands between the task, the [NAME] said he had not. The DM informed the [NAME] he could not use his bare hands to prepare the sandwiches. On 9/24/24 at 10:29 AM, the Dietary Aide (DA) was stacking the resident dinner plates in the plate cart with her bare hands. The DA picked the plates up with her fingers on the surface of the plate. The surveyor asked her why it was a problem to pick the plates up with her fingers. The DA said it can cause cross contamination because the residents have to eat out of them. On 09/24/24 at 2:47 PM, the DM checked the inside of the ice machine. She swiped the inside of the ice machine with a white paper towel. A black-pinkish substance came off on the white paper towel. The DM said her concern was cross contamination for the residents. On 9/24/24 at 10:39 AM, the wall adjacent to the dishwasher room, inside the kitchen was covered with a rust-colored substances running down the wall behind a shelf containing the cleaned dishes and tea pitchers.