

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045284	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/31/2024
NAME OF PROVIDER OR SUPPLIER Pocahontas Healthcare and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 105 Country Club Road Pocahontas, AR 72455	

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 - Few</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>43409</p> <p>Based on observations, interviews, record review, facility document review, and facility policy review, it was determined that the facility failed to promote the dignity of a resident who was observed with staff shaving in the dining room for 1 (Resident #6) 1 residents reviewed for dignity.</p> <p>The findings include:</p> <p>A review of the facility's undated policy titled resident rights and responsibility indicated The nursing facility protects and promotes the rights of each Resident/Elder admitted in order to provide a dignified existence, self-determination and communication with and access to persons and services inside and outside the nursing facility.</p> <p>A review of the facility's undated policy titled accident hazard prevention indicated .The facility is responsible for providing care to residents in a manner that helps promote quality of life. This includes respecting residents' rights to privacy, dignity and self-determination, and their right to make choices about significant aspects of their life in the facility.</p> <p>A review of the Admission Record indicated the facility admitted Resident #6 with diagnoses that included vascular dementia (a condition that affects thinking, memory and behavior due to poor blood flow to brain), unspecified psychosis (a set of symptoms that indicate a loss of contact with reality), and Alzheimer's disease.</p> <p>The admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 09/19/2024, revealed Resident #6 had a Brief Interview for Mental Status (BIMS) score of 0 which indicated the resident had severe cognitive impairment.</p> <p>A review of Resident #6's care plan, initiated on 09/17/2024, revealed the resident ' s usual performance was weight bearing assist with ADLs (activities of daily living). Interventions included personal hygiene: set up or clean up assistance. (Helper sets up or cleans up: resident completed task. Helper assists only prior to activity or following activity: combing hair, shaving, makeup, washing/drying face and hands.</p> <p>During an observation on 12/30/2024 at 11:44 AM, Certified Nursing Assistant (CNA) #1 was shaving Resident #6 in the dining room with two male residents and one female resident present.</p> <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 - Few</p>	<p>During a concurrent observation and interview, on 12/30/2024 at 11:47 AM, while shaving Resident #6, CNA #1 confirmed shaving male residents in the dining room because it was easier to do and continue to watch other residents. CNA #1 confirmed that shaving was not performed during meal services.</p> <p>During an interview on 01/01/2025 at 11:58 AM, the Director of Nursing (DON) confirmed shaving should be completed in resident rooms and not in the dining room due to dignity concerns.</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>43409</p> <p>Based on observation, interviews, and facility policy review, it was determined that the facility failed to ensure a portable oxygen cylinder was secured to prevent an accident or injury.</p> <p>The findings include:</p> <p>A review of the facility's undated policy titled Accident Hazards prevention indicated The environment will be free from an accident hazards as is possible .An effective way for the facility to avoid accidents is to develop a culture of safety and commit to implementing systems that address resident risk and environmental hazards to minimize the likelihood of accidents .</p> <p>A review of the facility's undated policy titled Handling of oxygen and flammable gas, indicated Oxygen cylinders will be stored in a designated ventilated area and stored in a safe manner to prevent cylinder from fall over.</p> <p>During an observation on 12/31/2024 at 2:04 PM, an unsecured portable oxygen cylinder was standing in front of the nursing station with residents and staff present. Two nurses were sitting behind the nursing station documenting. Three staff members were standing on the opposite side of the nursing station. Two residents were in the day area adjacent to the nursing station.</p> <p>During an interview on 12/31/2024 at 2:05 PM, Licensed Practical Nurse [LPN] 3 confirmed a portable oxygen tank should not be left unsecured due to a possibility of causing injuries if the tank fell over.</p> <p>During an interview on 12/31/2024 at 2:07 PM, LPN #2 confirmed an oxygen tank should be secured to prevent an accident or explosion.</p> <p>During an interview on 12/31/24 at 2:10PM, the Director of Nursing (DON) confirmed a portable oxygen tank should be secured to prevent an accident.</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>43409</p> <p>Based on observations, interviews, record review, and facility policy review, it was determined that the facility failed to ensure infection prevention and control practices were implemented to prevent the development of communicable diseases and infections as evidenced by failure to wear personal protective equipment (PPE) in a contact isolation room for 1 (Resident #7) of 1 resident reviewed for infection control.</p> <p>The findings include:</p> <p>A review of the facility's undated policy titled Transmission based precautions categories, indicated Contact precaution: a. Personal protective equipment: Gloves and gown. B. Wear PPE [personal protective equipment] for all interactions that may involve contact with the patient or potentially contaminated areas in the patient's environment. C. Donning PPE upon room entry and discarding before exiting the patient room is done to contain pathogens.</p> <p>A review of the admission record indicated the facility admitted Resident #7 with diagnosis that included extended spectrum beta lactamase resistance (an enzyme that some bacteria produce to break down antibiotics).</p> <p>The quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 10/25/2024, revealed Resident #7 had a Brief Interview for Mental Status (BIMS) score of 12 which indicated the resident had moderate cognitive impairment.</p> <p>A review of Resident #7's Care plan, revised on 10/30/2024, revealed the risk for multi-drug resistance organism (MDRO) Interventions included educating resident/family/staff on enhanced barrier precautions and answer questions, ensure isolation signage is posted.</p> <p>A review of physician orders revealed Resident #7 is on contact isolation for extended-spectrum beta lactamase (ESBL) in urine.</p> <p>During an observation on 12/30/2024 at 12:41 PM, Resident #7 had a contact isolation sign on door and PPE outside room.</p> <p>During an observation on 12/31/24 at 8:42 AM, Certified Nursing Assistant (CNA) #1 was in Resident #7 ' s room changing the resident ' s clothes and only wearing a mask and gloves.</p> <p>During a concurrent observation and interview, on 12/31/2024 at 8:44 AM, CNA #1 confirmed Resident #7 was on contact isolation and CNA #1 was only wearing a mask and gloves while changing the resident's clothes.</p> <p>During an interview on 12/31/2024 at 8:50 AM, Licensed Practical Nurse (LPN) #2 confirmed Resident #7 was on contact isolation due to ESBL and mask, gown, and gloves were required to provide personal care.</p> <p>(continued on next page)</p>		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview, on 12/31/2024 at 8:57AM, the Consultant confirmed mask, gown, and gloves were required to provide personal care in a contact isolation room.		