STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045300	A. Building B. Wing	08/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Paris Health and Rehabilitation Center	1414 S Elm St Paris, AR 72855

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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. 48630 Based on observations, interviews, record review, facility document review, and facility policy review, it was determined the facility failed to ensure that physician's orders for medications were followed during medication administration for 2 (Resident #24 and #92) of 6 residents reviewed for medication administration. The surveyor observed 31 medication opportunities with 2 errors noted, which was a 6.45% error rate for the facility. Findings include: A review of a facility policy titled, 6.0 General Dose Preparation and Medication Administration, dated 01/01/2013, indicated, Facility staff should verify that the medication name and dose are correct. During an observation on 08/07/2024 at 7:45 AM, Registered Nurse (RN) #4 administered multivitamin/multimineral 1 tablet to resident #92. During an observation on 08/07/2024 at 7:54 AM, RN #4 administered calcium with vitamin D3 600 milligrams (mg)/5 micrograms (mcg). 1 tablet to resident #24. A review of Physician Orders, revealed Resident #92 had an order for multivitamin tablet, 1 tablet by mouth daily this order was ordered on 12/18/2023. A review of Physician Orders, revealed Resident #24 had order for calcium with vitamin D 600 mg/ 10 mcg tablet. 1 tablet by mouth daily this order was ordered on 07/02/2024. During an interview on 08/07/2024 at 4:47 PM, the surveyor asked RN #4 to compare the medication that was given to Resident #92 and #24 to the medication administration record (MAR). RN #4 stated a multivitamin with minerals was given but the order was for a multivitamin for Resident #92 and vitamin D3 was not the accurate amount with Calcium for Resident #24. RN #4 stated both variations of the medications are the only available dose in the building. Surveyor asked, What is the importance of following physician's orders during medication administration? RN #4 stated, Follow physician's orders to make sure the resident is getting the correct medication ordered. (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

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 08/08/2024 at 7:10 PM, the Director of Nursing (DON) Resident #92 should have received a multivitamin but a multivitamin with minerals was received and Resident #24 was not given the correct strength of Vitamin D. The DON stated it is important to give the correct medications and dosages to ensure that Physician's orders are followed.

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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 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. 03508 Based on observation, interview, and facility policy review, 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 8 residents who received pureed diets. The findings are: 1. On 8/06/24 at 5:15 PM, a pan of pureed chicken alfredo to be served to the residents who required pureed diets was on the steamtable. The consistency of the pureed chicken alfredo was lumpy and not smooth. There were pieces of intact pasta visible in the mixture. 2. On 8/07/24 at 8:08 AM, the following observations were made on the steamtable during the breakfast meal service: a. A pan of pureed sausage. The consistency was gritty and not smooth. b. A pan of pureed bread. The consistency was thick. c. On 8/06/24 at 8:17 AM, the surveyor asked the Dietary Manager to describe the consistency of the pureed sausage and pureed oatmeal served to the residents at the breakfast meal. She stated, Pureed bread was thick and pureed sausage was not completely pureed. 3. On 8/07/24 at 10:33 AM, Dietary [NAME] (DC) #3 used a #8 scoop to put 10 servings of Spanish rice into a blender, added a can of tomato juice and pureed. At 10:41 AM, DC #3 poured the pureed Spanish rice into a pan, covered the pan with foil and place it in the oven. The consistency of the pureed rice was gritty. At 12:42 PM, the Dietary Manager was asked if she could describe the consistency of the pureed Spanish rice. She stated, It was gritty. 4. On 08/07/24 at 11:19 AM, DC #3 used a 2 -ounce spoon to place 12 servings of shredded lettuce and 12 servings of diced tomatoes into a blender, added 2 tablespoons of thickener and pureed. She poured the pureed salad into a pan. The consistency of the pureed salad was not formed and had tomato seeds in the mixture. At 2:19 PM, DC#3 was asked to describe the consistency of the pureed salad. DC #3 stated, The seeds are hard to puree. 5. A review of a facility policy titled, Pureed Foods Process #2 Preparing Pureed Foods, with an effective date of August 23, 2017, indicated whole foods should be pureed in a blender or a food processor to a semi-solid consistency, the consistency of applesauce or mashed potatoes.

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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. 03508 Based on observation, interview, and facility policy review, the facility failed to ensure foods stored in the freezer and dry storage area were covered, and sealed to minimize the potential for food borne illness for residents who received meals from 1 of 1 kitchen;1 of 1 ice machine in the kitchen was maintained in clean and sanitary condition to prevent food and beverage contamination and staff washed their hands between dirty and clean tasks and before handling clean equipment to minimize the potential for contaminating food items for residents who received meals from 1 of 1 kitchen. These failed practices had the potential to affect 96 residents who received meals from the kitchen. The findings are: 1. On 08/06/24 at 4:17 PM, an opened box of salt was on the shelf above the food preparation counter, the box was not covered. 2. On 08/06/24 at 4:37 PM, the ice machine in the kitchen had an accumulation of wet, black, slimy appearing residue around the area where ice forms before dropping into the ice collector. It was pointed out to the Dietary Manager and asked if the residue build up could be wiped off. She used tissue paper and wiped it off. The wet black residue easily transferred to the tissue. The Dietary Manager was asked if she could describe what was found on the panel. She stated, It was slimy black. The Dietary Manager was asked who used the ice from the ice machine and how often they cleaned it. We have a company that come s every 3 months to clean it. We use it in the kitchen to fill beverages served to the residents at mealtimes. 3. On 08/06/24 at 4:45 PM, an opened box of vegetable blend was on a shelf in the walk-in freezer. The bag was not covered or sealed. 4. On 08/06/24 at 5:02 PM, Dietary Aide (DA)#1 opened the refrigerator and removed trays that contained beverages and placed them on the counter, picked a maker and placed it in a container on the counter, contaminating her hands. Without washing her hands, she picked up glasses that contained beverages to be served to the residents for supper meal by the rims and placed them in a deep pan. She then pours ice around the drinks to keep them chilled before serving them to the residents at the supper meal. 5. On 08/06/24 at 5:30 PM, DA #1, who was on the tray assisting with the supper meal, was observed to pick up cartons of supplements and placed them on the trays, contaminating her hands. Without washing her hands, she picked up glasses and cups that contained beverages by the rims and placed them on the trays to serve to the residents with their meal. 6. On 08/06/24 at 5:36 PM, DA #1 on the tray line serving supper meal, was observed to pick up cups of juice and cartons of milk and placed them on the trays, contaminating their hands. Without washing their hands, she picked up glasses that contained beverages by the rims and placed them on the trays to serve the residents. At 5:53 PM, DA #1 was asked what she should have done after touching dirty objects and before handling clean equipment? DA #1stated, I should have washed my hands. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	7. On 8/06/24 at 5:39 PM, DC #2 was on the tray line serving supper meal. DC#2 picked up cartons of juice and cartons of sherbets and placed them on the trays. Without washing her hands, she picked up clean plates from the plate warmer and placed them on the trays with her fingers inside the plates. She then portioned food items on the plates and served them to the residents for supper meal. 8. A review of a facility policy titled, Handwashing Guidelines with effective date of February 1, 2002, provided by the Dietary Manager on 8/07/24 at 5:51 PM, indicated, Frequency of Handwashing .After hands have touched anything unsanitary, i.e., garbage, soiled utensils or equipment, and dirty dishes.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 48630 Based on observations, interviews, record review, facility document review, and facility policy review, it was determined that the facility failed to change contaminated gloves and perform hand hygiene during medication administration with a resident on enhanced barrier precautions (EBP) for 1 (Resident #26) of 1 resident reviewed for percutaneous endoscopic gastrostomy (PEG) tube medication administration. Findings include: A review of a facility policy titled, Hand Hygiene, dated 06/11/2020, indicated, The following is a list of some situations that require hand hygiene. Before and after direct resident care. Before and after entering isolation precaution settings. After handling soiled or used linens. A review of a facility policy titled, Enhanced Barrier Precautions, dated 04/29/2024, indicated, EBP requires donning of gown and gloves during high-contact resident care activities. EBP is employed while performing high-contact resident care activities including device care or use: feeding tube. A review of the Face Sheet, indicated the facility admitted Resident #26 with diagnosis of artificial openings of gastrointestinal tract. A review of Resident #26's Care Plan revealed the resident had potential for infection related to PEG-enhanced barrier precautions. Interventions included gown and gloves during high-contact care areas with an initiation date of 07/30/2024. A review of Physician Orders, revealed Resident #26 had an order enhanced barrier precautions ordered on 07/22/2024. During an observation on 08/07/2024 at 8:13 AM, Registered Nurse (RN) #4 was observed by the surveyor preparing Resident #26's medications in hallway on medication cart with gloves in place on both hands. RN #4 entered resident's room filled 3 large medicine cups with water in the bathroom and placed on resident's bedside table. RN #4 then pulled back the resident's linens and exposed the PEG tube. RN #4 then used the bed controller to raise the height of the resident's bed. All of this occurred while RN #4 was wearing the same pair of gloves. RN #4 then applied a gown prior to administering the resident's medications and left the same pair of gloves in place. During an interview on 08/07/2024 at 6:10 PM, the surveyor asked RN #4, Is Resident #26 on any precautions? RN #4 stated there were enhanced barrier precautions for PEG tube. The surveyor asked what personal protective equipment (PPE) is required for EBP, and RN #4 stated gown and gloves for extra precaution to prevent infection from transmission of a healthcare worker. The surveyor asked RN #4, What should have been done in between the preparation of Resident #26's medication and administration? RN #4 stated that gloves should have been changed and hand hygiene performed. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 08/07/2024 at 6:20 PM, the surveyor asked the Director of Nursing (DON), Is Resident #26 on any precautions? The DON stated EBP for PEG tube. The surveyor asked what personal protective equipment (PPE) is required for EBP? DON stated gown and gloves. It should be applied when walking into the room for PEG tube medication administration. Surveyor asked the DON, Should a glove change be performed in between medication preparation and PEG tube medication administration? The DON stated yes, the gloves should have been changed. The surveyor asked, What is the reasoning for EBP? DON stated, To protect the resident with an extra layer of protection from healthcare staff.