| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 045302 | A. Building<br>B. Wing | 11/15/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Innisfree Health and Rehab, LLC | 301 South 24th Street<br>Rogers, AR 72758 |

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| F 0577<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Allow residents to easily view the nursing home's survey results and communicate with advocate agencies.<br><br>49413<br><br>Through observation and interview the facility failed to post the results of the most recent survey of the facility in a place readily accessible to residents, family members and legal representatives of residents.<br><br>The findings are:<br><br>During observations from 11/11/2024 at 1:00PM through 11/15/2024 at 9:15AM, the only time residents were seen in the vicinity of the greeting desk was with the escort of facility staff, contracted therapy staff or contracted transportation staff.<br><br>During observations from 11/11/2024 at 1:00PM through 11/15/2024 at 9:15AM, the facility survey book was located on the far back right-hand side of the greeting desk. The greeting desk had a staff member assigned to the position. To obtain the facility survey book a resident or representative would be required to reach through the assigned staff members workstation. The facility survey book was back far enough to where a resident in a wheelchair would not have the ability to obtain the book without the need to ask.<br><br>Observations from 11/11/2024 at 1:00PM through 11/15/2024 at 9:15AM showed there was not a facility survey book openly located in any of the resident's common areas such as dining room, day room or individual hallways.<br><br>On 11/14/2024 at 1:04PM, Receptionist stated survey books were in the nurses' stations and receptionist desk at main entrance. There were not any survey facility books in the resident hall areas. Receptionist stated, a few people had asked about the facility survey book. People see the facility survey book and ask for it. Receptionist was not sure if the people who ask for the facility survey book were allowed to take it to a different location within the facility. The people who ask to look at the survey facility book usually sit at the reception desk area.<br><br>On 11/14/2024 at 1:22PM, an attempt was made to locate a facility survey book in which residents, nor their representatives would need to ask assistance for the survey book. LPN #5 confirmed a facility survey book was not at the long-term nurse's desk for hall one and does not know where the facility survey book is.<br><br>(continued on next page) |



| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| F 0577<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | On 11/14/24 1:30PM, the CNA Consultant confirmed the facility had only one survey book at the receptionist desk.<br><br>On 11/15/2024 at 8:25AM, during an interview, the Receptionist confirmed the survey book was kept on the far back, right-hand side of the greeting desk. Residents can ask for the survey book if they are unable to reach across the desk themselves.<br><br>On 11/15/2024 at 10:00AM, the Director of Nursing (DON) and Nurse Consultant confirmed that residents should have access to the survey book.<br><br>On 11/15/2024 at 10:01AM, the Administrator confirmed that residents should not have to ask for the survey book.<br><br>On 11/15/24 at 10:02AM, the Administrator was informed that the Receptionist stated the book was kept at the receptionist desk and the residents had to ask for it to see it but had to stay there with it. The Administrator stated that was the wrong answer and it would be rectified. |

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| F 0625<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave.<br><br>50924<br><br>Based on interviews, record review, facility document review, and facility policy review, it was determined that the facility failed to provide written bed hold notice for 1 (Resident #97) of 1 resident reviewed for hospitalization .<br><br>Findings include:<br><br>A review of the policy titles, Bed Hold Policy and Return, revised on 11/22/2016 indicated, the bed hold policy was sent with the resident to the hospital in case of a transfer or emergency. The resident or their representative would be contacted the next business day to identify if they want to hold the bed. It should be documented on the bed hold form, then filed in the business office. If contact was made by phone a witness is required to listen, and two signatures are required when filling out the bed hold form.<br><br>Review of an Admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 09/11/2024, revealed Resident #97 had a Brief Interview of Mental Status (BIMS) score of 15 which indicated the resident was cognitively intact.<br><br>Review of Resident #97 ' s Admission Record revealed Resident #97 was their own representative, but a spouse was listed as next of kin.<br><br>Review of Resident #97 ' s Order Summary Report revealed an admission order dated 09/06/2024 for skilled nursing. An order to transfer to the emergency room was placed on 09/20/2024 for altered mental status.<br><br>Review of Resident #97 ' s Activity Report revealed, Business Office Manager (BOM) charted on Friday, 09/20/2024, Resident #97's spouse did not know if the resident would return and would notify the BOM by Monday.<br><br>During an interview on 11/14/2024 at 1:08 PM, BOM stated, when a resident was transferred to the hospital it was their practice to call the family to see if they want to hold the bed. BOM stated, they called Resident #97's spouse, and it was unknown if the resident would return or not. BOM stated no bed hold agreement was issued for Resident #97 on 09/20/2024. |

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| F 0655<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted<br><br>37634<br><br>Based on observations, interviews, and record reviews, it was determined that the facility failed to ensure oxygen was on the care plan for 1 (Resident #28) of 1 sampled resident.<br><br>The findings are:<br><br>A review of Resident #28's Order Summary Report revealed a diagnosis of shortness of breath.<br><br>A review of Resident #28's Order Summary Report revealed an order dated 10/04/2024, for oxygen 1-4 liters by nasal cannula as needed for shortness of breath.<br><br>Review of a significant change Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 10/09/2024, revealed Resident # 28 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident was cognitively intact. Resident #28 had oxygen therapy while a resident.<br><br>A review of Resident #28's Care Plan did not indicate that Resident #28 was on oxygen.<br><br>On 11/12/2024 at 2:11 PM, an oxygen tank was observed in Resident #28's room. Resident #28 indicated that he used oxygen 2 days ago.<br><br>On 11/14/2024 at 3:23 PM, during an interview, the Long Term Care MDS Coordinator indicated that Resident #28 ' s oxygen was not on the care plan, and she did not know why it was not on there.<br><br>On 11/14/2024 at 3:26 PM, the Skilled MDS Coordinator indicated that Resident #28 oxygen was not on the care plan, and she did not know why.<br><br>On 11/15/2024 at 12:20 PM, the Administrator stated that the facility does not have a policy on care plans. |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>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.<br><br>50505<br><br>Based on observations, interviews, and record review, it was determined that the facility failed to ensure the care plan was updated to include contracture and contracture management for 1 resident (Resident #13) of 1 resident reviewed for positioning and mobility and contracture management.<br><br>Findings include:<br><br>No policy was provided for contracture management.<br><br>A review of the Admission Record, indicated the facility admitted Resident #13 with diagnoses that included dementia, pain, muscle wasting and atrophy, and hemiplegia (partial or complete paralysis to one side of the body).<br><br>Review of a quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 09/18/2024, revealed Resident #13 had a Brief Interview for Mental Status (BIMS) score of 7 which indicated the resident had severe cognitive impairment. Resident #13 was shown to have an impairment of the upper and lower extremity for functional limitation in range of motion.<br><br>A review of Resident #13's Care Plan, initiated on 11/14/2024, revealed the resident had an alteration in musculoskeletal status related to contracture (left hand and arm). This care plan was initiated after speaking with the Long-Term Care Minimum Data Set (LTC MDS) Coordinator. The newly initiated care plan did not include the restorative program or the functional maintenance plan (FMP) in which Resident #13 had been participating in. There was no mention of a hand roll or device for preventing the worsening of the left-hand contracture.<br><br>A review of an Activity of Daily Living Task revealed no task was being documented.<br><br>A review of the closet care plan for Resident #13 revealed a special device, a hand roll, was needed in the left hand.<br><br>During an observation on 11/12/2024 at 2:58 PM, Resident #13 was in activity, in the main dining room where staff were assisting residents with painting. Resident #13 was sitting at a table with the painting supplies and picture in front of the resident. Resident #13 had left-hand lying-in lap and was not moving the left hand or arm.<br><br>During an observation and concurrent interview on 11/14/2024 at 2:05 PM, the LTC MDS coordinator stated that Resident #13 had a restorative program, and that the FMP had been extended then confirmed that after Resident #13 had been evaluated by therapy, no recommendations had been made for a splint or brace. LTC MDS Coordinator confirmed Resident #13 had been receiving restorative three times a week. When asked how the staff would know what type of care to provide to Resident #13, it was confirmed the resident had a closet care plan. LTC MDS coordinator removed the closet care plan for review, and it stated that Resident #13 needed a hand roll to the left hand.<br><br>(continued on next page) |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During an observation on 11/14/2024 at 2:10 PM, Resident #13 was sitting in bed with the head of the bed elevated up and the over-the-bed table was across the bed in front of the resident. The lunch tray was in front of Resident #13 without anything eaten off the tray. Resident #13 was asked if help was needed to eat and the response was given, yes. LTC MDS coordinator stated that someone would help with the tray. Resident #13 did not have any device in the left hand, which was beside the resident in the bed.<br><br>During an interview with a Certified Nursing Assistant (C.N.A.) #8 on 11/14/2024 at 2:14 PM, confirmation was given that Resident #13's closet care plan stated a hand roll was needed for the left hand. When C.N.A. #8 was asked if Resident #13 ever used a hand roll in the left hand, the answer was given, No.<br><br>During an interview on 11/15/2024 at 11:30 AM, the DON confirmed there was no documentation concerning use of a hand roll for Resident #13 ' s left hand. The DON provided a newly initiated care plan with no mention of a hand roll, restorative program or the functional maintenance plan (FMP). When asked what guidance the LTC MDS coordinator used to develop and complete the MDS and care plan, DON stated, I am not sure, and the LTC MDS coordinator only works part time and is not at the facility today. |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate treatment and care according to orders, resident's preferences and goals.<br><br>50505<br><br>Based on observations, interviews, record review, facility document review, it was determined that the facility failed to ensure the resident was provided hand roll for contracture management for 1 (Resident #13) of 1 resident reviewed for providing contracture management.<br><br>Findings include:<br><br>No policy was provided for contracture management.<br><br>A review of the Admission Record, indicated the facility admitted Resident #13 with diagnoses that included dementia, pain, muscle wasting and atrophy, and hemiplegia (partial or complete paralysis to one side of the body).<br><br>Review of a quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 09/18/2024, revealed Resident #13 had a Brief Interview for Mental Status (BIMS) score of 7 which indicated the resident had severe cognitive impairment. Resident #13 was shown to have an impairment of the upper and lower extremity for functional limitation in range of motion.<br><br>A review of Resident #13's Care Plan, initiated on 11/14/2024, revealed the resident had an alteration in musculoskeletal status related to contracture (left hand and arm). This care plan was initiated after speaking with the Long-Term Care Minimum Data Set (LTC MDS) Coordinator. The newly initiated care plan did not include the restorative program or the functional maintenance plan (FMP) in which Resident #13 had been participating in. There was no mention of a hand roll or device for preventing the worsening of the left-hand contracture.<br><br>A review of an Activity of Daily Living Task revealed no task was being documented on<br><br>A review of the closet care plan for Resident #13 revealed a special device, hand roll was needed in the left hand.<br><br>During an observation on 11/12/2024 at 2:58 PM, Resident #13 was in activity, in the main dining room where staff were assisting residents with painting. Resident #13 was sitting at a table with the painting supplies and picture in front of the resident. Resident #13 had left hand lying in lap and was not moving the left hand or arm.<br><br>During an observation and concurrent interview on 11/14/2024 at 2:05 PM, the LTC MDS coordinator stated that Resident #13 had a restorative program, and that the FMP had been extended and confirmed that after Resident #13 had been evaluated by therapy, no recommendations had been made for a splint or brace. LTC MDS Coordinator confirmed that Resident #13 had been receiving restorative three times a week. When asked how the staff would know what type of care to provide to Resident #13, it was confirmed the resident had a closet care plan. The LTC MDS coordinator removed the closet care plan for review, and it stated that Resident #13 needed a hand roll to the left hand.<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an observation on 11/14/2024 at 2:10 PM, Resident #13 was sitting in bed with the head of the bed elevated up and the over-the-bed table was across the bed in front of the resident. The lunch tray was in front of Resident #13 without anything eaten off the tray. Resident #13 was asked if help was needed to eat and the response was given, yes. LTC MDS coordinator stated that someone would help with the tray. Resident #13 did not have any device in the left hand, which was beside the resident in the bed.<br><br>During an interview with a Certified Nursing Assistant (C.N.A.) #8 on 11/14/2024 at 2:14 PM, confirmation was given that Resident #13's closet care plan stated a hand roll was needed for the left hand. When C.N.A. #8 was asked if Resident #13 ever used a hand roll in the left hand, the answer was given, No.<br><br>During an interview on 11/15/2024 at 11:30 AM, the Director of Nursing (DON) confirmed there was no documentation concerning use of a hand roll for Resident #13 ' s left hand. The DON provided a newly initiated care plan with no mention of a hand roll, restorative program or the functional maintenance plan (FMP). When asked what guidance the LTC MDS coordinator used to develop and complete the MDS and care plan, the DON stated, I am not sure, and the LTC MDS coordinator only works part time and is not at the facility today. |

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| F 0758<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited.<br><br>37634<br><br>Based on interviews and record review the facility failed to ensure 1 (Resident #42) of 5 sampled residents that were reviewed for unnecessary medication did not have an order to receive a PRN (as needed) medication past 14 days without justification, and an evaluation by the doctor.<br><br>The findings are:<br><br>Review of a quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 10/23/2024, revealed Resident #42 had a Brief Interview of Mental Status (BIMS) score of 14, which indicated the resident was cognitively intact.<br><br>Review of Resident #42's Care Plan initiated 7/19/2021, indicated to administer antidepressant medication as ordered by physician.<br><br>Review of Resident #42's Order Summary Report with an order date of 11/11/2024, revealed anti-anxiety tablet 1 milligrams (mg) was ordered every 2 hours as needed for anxiety related to anxiety disorder for 45 Days. A rationale for the prn anti-anxiety medication was not in the clinical records.<br><br>During an interview on 11/15/2024 at 8:22 AM, Physician Assistant indicated that the duration of as needed anti-anxiety medication was typically 15 days, unless evaluated for 30-60 days. Physician Assistant indicated she did not order the as needed anti-anxiety medication for Resident #42. She indicated that hospice ordered the medication, and she had to put the medication order in her name.<br><br>During an interview on 11/15/2024 at 8:30 AM, Nurse Consultant indicated the facility does not have any information in the system on the rationale for the order of as needed anti- anxiety medication for Resident #42.<br><br>On 11/15/2024 at 12:10 PM Director of Nurse indicated as needed anti-anxiety medication should be ordered for 14 days. She indicated if as needed anti-anxiety medication was ordered for more than 14 days a documented rationale should be in the clinical record. DON stated if the facility nurse received a verbal order from hospice the nurse should have recorded the reason for the medication.<br><br>On 11/15/2024 at 12:20 PM, the Director of Nurse stated the facility does not have a policy for as needed medication. |

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| F 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50924<br><br>Based on observations, interviews, and facility policy review, it was determined that the facility failed to remove two bottles of expired tube feeding from current stock for 1 of 1 medication room and failed to label two insulin vials and three inhalers with open dates when the manufactures seal was broken in 2 of 2 medication carts reviewed for medication storage.<br><br>Findings include:<br><br>A review of a facility policy titled, Medication Storage in the Facility, revised in [DATE] indicated, when the original seal of a manufacturer's container or vial is initially broken, the container or vial will be dated. The nurse shall place a date opened and enter the date opened.<br><br>During a concurrent observation and interview on [DATE] at 9:07 AM, of the Long Term Care medication room with Licensed Practical Nurse (LPN) #5, two bottles of tube feeding in current stock were revealed to have expiration dates of [DATE]. LPN #5 stated, the bottles needed to be thrown away.<br><br>During a concurrent observation and interview on [DATE] at 9:22 AM, of 300-Hall medication cart with LPN #10, two vials of insulin were found without an opened date. Open dates were on the plastic bags but not labeled on the vial. LPN #10 stated yes, the bag could become damaged or lost resulting in an unknown open date. One inhaler was found without an open date on the canister or the packaging.<br><br>During a concurrent observation and interview on [DATE] at 10:00 AM, of 100-Hall medication cart with LPN #11, two inhalers were found without an open date on the canister or packaging.<br><br>During an interview on [DATE] at 10:30 AM, the Director of Nursing (DON) stated LPN #5 was tasked with checking expiration dates in the Long Term Care medication room and thought checks were done weekly. The DON was unaware nursing staff was labeling the bags and not the insulin vials. |

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| F 0804<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature.<br><br>03508<br><br>Based on observation, record review, and interview, the facility failed to ensure meals were prepared in a method that maintained an appearance that was acceptable to the residents to encourage good nutritional intake for 2 of 2 meals observed.<br><br>The findings are:<br><br>1. A review of the facility recipe titled, Egg sausage bake initiated 9/17/2024 and provided by the Dietary Manager on 11/14/2024 indicated use water or stock.<br><br>2. On 11/13/24 at 4:14 PM, Dietary [NAME] (DC) #1 placed 10 servings of egg sausage bake into a blender and pureed. DC #1 did not add broth or anything to help moisten it. At 4:24 PM, DC #1 poured the pureed sausage with egg casserole into a pan and placed it in the oven. The consistency was thick when it was placed in the oven and remained thick when it was placed on the steam table to serve. On 11/14/24 at 12:55 PM, DC #1 was asked what he used when pureeing egg sausage bake to make it moist. DC #1 indicated that he did not use anything.<br><br>3. On 11/13/24 at 4:32 PM, DC #1 placed 10 servings of biscuits into a blender, ground, then added warm milk from a pan on the counter and pureed. DC #1 scooped pureed biscuit into a pan, and it was thick. At 4:42 PM. Dietary Aide (DA) #2 transferred pureed biscuit back into a blender, added a carton of whole Milk I and pureed it some more. At 4:43 PM, DA #2 scooped pureed biscuits into a pan and placed it in warmer. The consistency was sticky and thick.<br><br>4. On 11/13/24 at 4:59 PM, DC #1 placed 10 servings of hash brown into a blender, added 3 more servings of hash brown, added milk and pureed. At 5:05 PM, DC #1 used a spatula to scrape pureed hash brown into a pan. It was sticky and thick.<br><br>5. Resident #42's Order Summary Report was reviewed and indicated the resident had a diagnosis of Dysphagia following cerebral infarction, and an order dated 10/23/2024 for Regular diet pureed texture, honey consistency, half portions.<br><br>Review of a quarterly Minimum Data Set with an Assessment Reference Date of 10/23/2024, was reviewed and indicated Resident #42 had a score of 14 (13-15 indicates cognitively intact) on the Brief Interview for Mental Status (BIMS) and required partial/moderate assistance for eating substantial/maximal assistance for personal hygiene, and partial/moderate assistance for mobility.<br><br>6. On 11/14/24 at 9:40 AM, Resident #42 was lying on back in bed. Resident #42 was served pureed pancake and pureed fruit desert. The consistency of the pureed pancake was too thick, and when attempting to cut a portion of the pureed pancake on the plate to eat was unable to do so. The resident indicated that trying to take a bite of pureed pancake, but it was too hard. At 9:43 AM, resident #42 was asked how dinner last night was. Resident #42 stated they were like this pureed and I could not eat it.<br><br>(continued on next page) |

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| | 045302 | A. Building<br>B. Wing | 11/15/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Innisfree Health and Rehab, LLC | 301 South 24th Street<br>Rogers, AR 72758 |

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| F 0804<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | 7. On 11/14/24 at 9:44 AM, the Assistant Dietary Manager (ADM) was asked about the consistency of the pureed pancake and cream of wheat served to the residents on pureed diets at the breakfast meal. She stated cream of wheat was runny and pureed pancake was too thick. She indicated that the bread on resident #42's tray looked formed and hard. When asked about the pureed biscuits and pureed sausage and egg served at the super meal on 11/13/24 ADM confirmed the pureed sausage with eggs and pureed biscuit were thick.<br><br>8. On 11/14/24 at 12:43 PM, DA #2 was asked how the pureed food items served at the supper meal on 11/13/24 looked. DA #2 stated pureed sausage with eggs were too thick and he should have added more liquid. Pureed biscuits were thick, and he should have added more liquid. Pureed hash brown was thick and needed more liquid.<br><br>9. On 11/14/24 at 12:48 PM, the Dietary [NAME] #4 was asked how cream of wheat served to the residents on pureed diets at breakfast looked. DC #4 stated most residents asked for their cream of wheat to be thin, but confirmed pureed cream of wheat should not have been soupy, it should have been a little thick.<br><br>10. On 11/15/24 at 8:42 AM, the speech therapist when interviewed was asked how the consistency of pureed diets should look. She stated it should look like pudding or mashed potato consistency, should hold its shape in a spoon with no lumps. She was asked if pureed food items should be thick, she stated the pureed foods should not be thick and residents on pureed diets should not put it in their mouth. |

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| F 0810<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide special eating equipment and utensils for residents who need them and appropriate assistance.<br><br>37634<br><br>Based on observations, interviews, and record reviews, it was determined that the facility failed to ensure a device to help keep food on a plate while eating was available for 1 (Resident #42) of 1 sampled resident who required adaptive equipment for meals.<br><br>The findings are:<br><br>A review of Resident #42's Order Summary Report indicated a diagnosis of unspecified lack of coordination, Parkinsonism, hemiplegia (partial or complete paralysis to one side of the body) and hemiparesis (muscle weakness or partial paralysis to one side of the body) of the cerebral dominant side (left side of the brain).<br><br>Review of a Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 10/23/2024, revealed Resident #42 had a Brief Interview of Mental Status (BIMS) score of 14, which indicated the resident was cognitively intact. Resident #42 required partial/moderate assistant with bringing food and or liquid to the resident ' s mouth once the meal was placed in front of the resident.<br><br>Review of Resident #42's Care Plan initiated 07/24/2024, indicated a plate guard should be used for all meals.<br><br>Review of Resident #42 ' s tray card dated 11/12/2024, indicated that the resident should have a plate guard.<br><br>On 11/12/2024 at 1:05 PM, Resident #42 was in room without staff eating lunch. Resident ' s tray card indicated that the resident was a total assist with meals. Resident #42 indicated they were supposed to have a section plate, but there was only one in the building. Resident #42 ' s food was on a regular plate. There was not a plate guard on the plate.<br><br>On 11/14/24 at 9:29 AM, Resident #42 was in bed eating breakfast. The resident did not have a plate guard on the plate. Resident #42 was having trouble picking up the bread.<br><br>During an interview on 11/14/24 at 9:43 AM, the Assistant Dietary Manager indicated Resident #42 did not have a plate guard on resident ' s plate but should have one.<br><br>On 11/15/24 at 8:06 AM, Certified Nurse Assistant #12 was in the room assisting Resident #42 with breakfast. Resident #42 was eating with a built-up spoon and fork. Resident #42's meal was served on a divided plate. Certified Nurse Assistant #12 indicated that today was the first time she has seen Resident #42 using a divided plate. Certified Nurse Assistant #12 indicated that she has never seen Resident #42 with a plate guard.<br><br>On 11/15/24 9:13 AM, the Rehabilitation Director indicated that she was informed by the Director of Nurse (DON) that Resident #42 was spilling food on self, and Resident #42 requested a section plate. The Rehabilitation Director indicated that she was not sure if Resident #42 was evaluated for spilling food on self.<br><br>(continued on next page) |

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| F 0810<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 11/15/2024 at 12:03 PM, the Director of Nurse (DON) stated the facility did not have a policy on adaptive equipment. |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 03508<br><br>49981<br><br>Based on observation, interview, record review and facility policy review, the facility failed to ensure dietary staff changed gloves and washed their hands before handling food items and clean equipment when contaminated; food items stored in the refrigerator and freezer were covered, sealed, and dated; expired food items were promptly removed/discarded on or before the expiration or use by date.<br><br>The findings are:<br><br>1. On [DATE] at 2:54 PM, Dietary [NAME] (DC) #1 was wearing gloves on his hands when he picked up a spray bottle and sprayed inside of the pans, contaminating the pans. Without changing gloves and washing his hands, DC #1 removed hash browns from a box and placed them on the pans to be baked and served to the residents for supper meal.<br><br>2. On [DATE] at 2:59 PM, the following observations were made on a shelf in the freezer.<br><br>a. An opened box of breaded pork patties. The box was not close or sealed.<br><br>b. An opened box of turkey burgers. The box was not covered or sealed.<br><br>c. An opened box of pie dough. The box was not covered or sealed.<br><br>3. On [DATE] at 3:04 PM, the following observations were made on a shelf in the walk-in refrigerator.<br><br>a. One container of leftover gravy indicated to use by [DATE].<br><br>b. Another container of leftover gravy indicated used by [DATE].<br><br>c. One container of taco sauce indicated used [DATE].<br><br>4. On [DATE] 3:13 PM, an opened box of cream of wheat was on a shelf in the storage room. A container of leftover gravy was on a shelf in the refrigerator with a used by date of [DATE].<br><br>5. On [DATE] at 3:34 PM. the following observations were made on a shelf in the emergency food supply in the kitchenette on 100-hall.<br><br>a. An opened bag of brown sugar. The bag was not sealed.<br><br>b. An opened plastic bag of pancake mix. The bag was not sealed.<br><br>c. An opened bag of protein breadcrumbs. The bag was not sealed.<br><br>(continued on next page) |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | 6. On [DATE] 4:18 PM, DC #1 was wearing gloves when he used a pair of scissors to cut out a piece of the plastic bag, and then inserted it into a pan. With his contaminated gloved hand, DC #1 pushed the plastic inside the pan that was intended for storing pureed food.<br><br>7. On [DATE] at 7:45 AM, Dietary Aide #3 (DA) was on the tray line assisting with breakfast meal. She picked up condiments and cartons of supplement and placed them on the meal trays. Without washing her hands, picked up glasses that contained beverages to be served to the residents for breakfast by the rims and placed them on the trays.<br><br>8.On [DATE] at 8:33 AM, DA #3 was asked what she should have done after touching dirty objects and before handling clean equipment. She stated, she should have washed her hands.<br><br>9. A review of policy titled, Proper Hand Washing procedure not dated, and provided by the Nurse Consultant indicated consider using a paper towel to create a barrier between hands and surfaces touched after hand washing (faucet and door handles).<br><br>10. On [DATE] at 11:10AM, the CNA Consultant was asked to assist with inspection of freezer and refrigerator in Activities Room of facility. The CNA Consultant opened freezer and confirmed that the temperature was 0 degrees. A box of popsicles was pulled out that had been opened with an expiration date of [DATE]. There was no open date. A container of green sherbet was observed that had not been opened and had an expiration date of [DATE]. Two boxes of cookie dough had been opened, and the bags were not sealed and no open date on either of the boxes was observed.<br><br>11. The CNA Consultant then opened the refrigerator, which had an internal temperature of 39 degrees Fahrenheit. The CNA Consultant pulled out 3 bags of ice cream sprinkles that had been opened and had no opened date. The CNA Consultant pulled from the refrigerator, a zipper sealed bag with opened brownie and pancake, opened [NAME] mix, and an opened bottle of soda, and none had opened dates.<br><br>12. On [DATE] at 11:48AM, the Activities Director (AD) was asked to describe the process for storing foods in the refrigerator and freezer in the Activities Room. The AD said the food came from the kitchen and was dated and placed in the freezer or refrigerator. Once the foods were opened, an open date was placed on container. Foods opened were sealed back up and placed back in freezer or refrigerator. The AD was asked to show opened dates on the items in the freezer and refrigerator in the Activities Room. The AD confirmed that there were no open dates on popsicles, sherbet, cookie dough, sprinkles, brownie and pancake mixes, [NAME] mix, and soda. The AD confirmed that foods should have opened dates and should be properly sealed in order to protect for food safety. |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide and implement an infection prevention and control program.<br><br>50505<br><br>Based on observations, interviews, record review, facility document review, facility policy review, it was determined that the facility failed to properly store oxygen tubing and Continuous Positive Airway Pressure (CPAP) tubing and mask for 2 (Resident #13-oxygen tubing and Resident #52-CPAP tubing and mask) of 2 residents reviewed for Infection prevention and control of equipment or devices.<br><br>Findings include:<br><br>A review of a facility policy titled, Oxygen Safety, revised on 11/22/2016, indicated, the facility would properly handle oxygen.<br><br>During an interview, Director of Nursing (DON) stated the facility did not have a policy regarding cleaning and storage of CPAP and oxygen tubing and other devices when not in use.<br><br>A review of an Admission Record, indicated the facility admitted Resident #13 with diagnoses that included shortness of breath, Type 2 Diabetes Mellitus, and chronic obstructive pulmonary disease (COPD).<br><br>Review of a quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 09/18/2024, revealed Resident #13 had a Brief Interview for Mental Status (BIMS) score of 7 which indicated the resident had severe cognitive impairment. Resident #13 had respiratory treatment which included oxygen therapy.<br><br>A review of Resident #13's Care Plan, initiated on 09/19/2024, revealed the resident was on oxygen therapy. Interventions included that oxygen settings were to be set at 2-4 liters per minute via nasal cannula.<br><br>A review of the Order Summary Report, revealed Resident #13 had an oxygen order for 2-4 liters per minute via nasal cannula as needed for shortness of breath. There was no order located in the electronic medical record to indicate oxygen tubing change was completed weekly to prevent infections and contamination of oxygen tubing.<br><br>A review of Medication Administration Record, revealed Resident #13 had not been signed as having received Oxygen therapy for the dates of November 1, 2024, through November 14, 2024, nor was oxygen therapy marked for use from October 1, 2024, through October 31, 2024.<br><br>A review Resident #13 ' s progress notes, revealed Resident #13 had one note entered on 10/17/24 noting resident's shortness of breath and being non-compliant with leaving the nasal cannula in the nose.<br><br>During an observation on 11/14/2024 at 8:56 AM, after entering the room upon roommate's consent, an oxygen concentrator was heard. The curtain was pulled. Oxygen tubing was noted to be lying on Resident #13's bed with the oxygen concentrator running. The resident was not in the room at the time.<br><br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | A review Resident #52 ' s Admission Record, indicated the facility admitted Resident #52 with diagnoses of Alzheimer's disease, hypersomnia (excessive daytime sleepiness), and obstructive sleep apnea.<br><br>Review of Resident #52 ' s annual MDS with an ARD of 09/18/2024, revealed Resident #52 had a Staff Assessment for Mental Status (SAMS) which indicated memory problems. The MDS was not marked as resident having special treatments, procedures and programs for the CPAP.<br><br>A review of Resident #52's Care Plan, indicated no care plan for the use or care of the CPAP had been developed.<br><br>A review of an Order Summary Report, revealed Resident #52 had an order for CPAP settings: Mode: Auto. Wife will clean nasal pillow and tubing daily. Resident #52 to wear at the hour of sleep as tolerated and is to be removed in the morning. No order for the CPAP pressure rate or how often the CPAP tubing and nasal pillow was to be changed.<br><br>A review of Resident #52 ' s TAR, revealed Resident #52 had the order for the CPAP nasal pillow and tubing to be cleaned by the wife daily. Time for the task to be marked off the TAR was at 8:00 PM. Two omissions were noted on November 2 and November 10 with no signatures for the task being completed.<br><br>During an observation on November 14, 2024, at 8:51 AM, the CPAP nasal pillow was lying directly on the nightstand. No plastic bag was available for the placement of the CPAP tubing or nasal pillow.<br><br>During concurrent observation and interview on 11/14/2024 at 9:21 AM, the Director of Nursing (DON) was shown the CPAP nasal pillow for Resident #52, lying on the nightstand. Confirmation was given at that time by the DON was that the tubing should have been bagged.<br><br>During an interview on 11/15/2024 at 9:30 AM, LPN #7 stated oxygen tubing for Resident #13 should be stored in a plastic bag when not in use and when it becomes contaminated, the tubing should be replaced. LPN #7 stated the nurses on Sunday are responsible for changing out the tubing and that it would be documented in the medical record when completed. LPN #7 stated that the nasal pillow for the CPAP for Resident #52 should be in a plastic bag. When asked if the CPAP and the cleaning of the equipment was care planned, LPN #7 stated I don't know.<br><br>During an interview on 11/15/2024 at 11:30 AM, the DON confirmed nurses are responsible for cleaning and storage of oxygen tubing and supplies as well as making sure that CPAP tubing, masks and supplies are kept in a bag as well. The DON confirmed that once tubing becomes contaminated, the tubing or mask should be replaced. |

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| F 0919<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Make sure that a working call system is available in each resident's bathroom and bathing area.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49413<br><br>Through observations, record review, and interviews the facility failed to ensure residents were able to call for staff assistance through a communication system which relays the call directly to a staff member or to a centralized staff work area from their bed. This affected 4 (Residents #5, #24, #84, and #250) of 19 sampled residents.<br><br>The findings are:<br><br>Record Review of Resident #250 ' s Admission Report dated 10/25/2024, showed diagnoses of communication difficulties, abnormal mobility, left side weakness and/or paralysis after a stroke, and nerve malfunctions.<br><br>Record Review of Resident #250 ' s Minimum Data Set, dated dated dated [DATE] showed Section C Cognitive Pattern to have a Brief Interview for Mental Status (BIMS) of 15. Section GG Functional Abilities showed impairment on one side upper and lower extremity and use of wheelchair was required. Section GG Functional Abilities on OBRA/Interim showed staff was required to help with more than half of the effort for Resident #250 to go from a seated position to a standing position and a standing position to a seated position. Resident #250 required more than half the assistance from staff to roll from side to side while in bed.<br><br>Observation on 11/12/2024 at 11:50AM, of Resident #250 asleep with the call light on the right-side floor of bed. The call light cord was caught between the right side of the bed and the left side of the reclining chair. The call light cord was in a position where Resident #250 was unable to pull the call light pad within reach to be utilized for assistance.<br><br>Observation on 11/12/2024 at 2:00PM of Resident #250 asleep with the call light on the right-side floor of bed. The call light was not within reach, nor had the call light been clipped to Resident #250 ' s bed covers.<br><br>Record Review of Resident #84 ' s Admission Report dated 07/9/2024, showed diagnoses of decreased muscle strength and mass, altered mental state, osteoporosis, and repeated falls.<br><br>Record Review of Resident #84 ' s Minimum Data Set, dated dated dated [DATE], showed Section C Cognitive Pattern to have a BIMS of 11. Section GG Functional Abilities Functional Limitation in Range of Motion showed impairment on left and right sides from hip to toes, use of a wheelchair is required. Section GG functional Abilities Admissions showed<br><br>Resident #84 required total staff assistance for dressing and personal hygiene. Section GG Functional Abilities OBRA/Interim Resident #84 required total staff assistance for rolling side to side while in bed, seated position to a standing position and a standing position to a seated position. Resident #84 is unable to walk due to medical condition or safety concerns. Resident#84 was unable to maneuver wheelchair and was dependent on staff for transportation.<br><br>(continued on next page) |

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|---|---|
| F 0919<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Observation on 11/13/24 at 6:50AM, of Resident #84's call light on the floor of the right side of the bed. Resident #84 asked surveyor to place the call light where it could be reached. Resident #84 asked Surveyor to bring the bed control remote, that was at the foot of the bed, to where it could be reached. Resident #84 stated that staff was good at putting both controls at the foot of the bed.<br><br>On 11/13/24 6:56 AM, Resident #84 was then able to press the call light for staff assistance.<br><br>On 11/14/2024 10:45AM, Resident #84 ' s call light was dangling from the bedside rail while Resident #84 was asleep.<br><br>Record Review of Resident #24 ' s Admission Report dated 10/10/2017, showed diagnoses of stroke, dementia, history of falls, pain, major depression and anxiety.<br><br>Record Review of Resident #24 ' s Minimum Data Set, dated dated dated [DATE], showed Section C Cognitive Pattern to have a Staff Assessment for Mental Status of 3, severely impaired never/rarely made decisions. Section GG Functional Abilities showed Resident #24 required a wheelchair. Section GG Functional Abilities OBRA/Interim Resident #24 was dependent on staff for dressing, hygiene, rolling side to side while in bed, seated position to a standing position and a standing position to a seated position.<br><br>First observation of Resident #24 on 11/14/24 at 9:32AM, call light on the stationary bedside table on the left side of bed. Resident #24 would be unable to reach cord to pull the call light due to call light cord behind the bed mattress.<br><br>Second observation of Resident #24 on 11/14/2024 at 12:38PM, showed the call light remained in same position as the 9:32AM observation.<br><br>Record Review of Resident #5 ' s Admission Report dated 11/14/2018, showed diagnoses of pain in right hip, anxiety, depression, dementia, glaucoma (eye disease that can lead to optic nerve damage and loss of vision), and arthritis.<br><br>Record Review of Resident #5 ' s Minimum Data Set, dated dated dated [DATE], showed Section C Cognitive Pattern to have a BIMS of 4. Section GG Functional Abilities OBRA/Interim showed staff does more than half the work for Resident #5 during dressing, rolling side to side while in bed, seated position to a standing position and a standing position to a seated position.<br><br>First observation on 11/14/2025 at 10:10AM of Resident #5, call light was on the floor with the call light cord behind the head of the bed and draped over the bottom metal piece that connects the handrail to the bed. The call light cord was in a position where Resident #5 would be unable to reach the cord to pull the call light to be within reach for proper use.<br><br>Second observation on 11/14/2025 at 11:15AM of Resident #5 showed the call light remained in the same position as the first observation.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 045302 | A. Building<br>B. Wing | 11/15/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Innisfree Health and Rehab, LLC | 301 South 24th Street<br>Rogers, AR 72758 |

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 0919<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | On 11/14/24 at 3:26PM, the CNA Consultant confirmed that Resident #5 ' s call light should be within reach. The CNA Consultant placed the call light in the proper location on the bed next to Resident #5 ' s hand. The CNA Consultant confirmed the call light should be clipped to the bed covers or within a residents' reach. The call light in the proper position allows the residents to get assistance when needed.<br><br>On 11/14/24 at 3:31PM, the DON confirmed the call light was needed for resident assistance. There are clips to help keep the call light in place.<br><br>On 11/15/24 at 9:50AM, per Nurse Consultant the facility did not have a call light policy.<br><br>On 11/15/2024 at 9:54AM, the Administrator confirmed that call light needed to be within reach of the resident. There was a clip on the call light to clip it in place. It is unacceptable for the call light to not be within reach.<br><br>On 11/15/2024 at 11:15AM, the Nurse Consultant confirmed the facility had neither a policy nor procedure for call lights. The Nurse Consultant was able to provide a single call light in-service for answering call lights within a timely manner. |