STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045327	A. Building B. Wing	10/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ridgecrest Health and Rehabilitation	5504 E Johnson Ave Jonesboro, AR 72401

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37634 Based on observations, interviews, and record reviews, it was determined the facility failed to administer medications within the recommended time frame for 1 (Resident #3) of 3 (Resident # 1, Resident #3, and Resident #4) sampled residents. The findings are: The quarterly Minimum data Set (MDS), dated [DATE], revealed Resident #3 had a Brief Interview for Mental Status (BIMS) score of 09, which indicated the resident had moderate cognitive impairment. Review of Resident #3's Care Plan revised on 05/09/2023, revealed the resident received pain medication. Interventions included administering analgesic medications as ordered by physicians. On 10/29/24 at 9:27 AM Licensed Practical Nurse (LPN) #1 indicated she was passing morning medications late because she's had 17,000 things happen. She indicated the medications should have been passed by 9:00 AM. On 10/29/24 at 11:10 AM, LPN #1 was observed pulling medications for Resident #3. On 10/29/24 at 11:19 AM, LPN #1 had medications in a medication cup on top of the medication cart. The Medicare Manager walked up to the medication cart and asked LPN #1 who the medications in the cup belonged to. LPN #1 informed the Medicare Manager the medications were for Resident #3. The Medicare Nurse picked up the cup of medications and a cup of water and walked over to Resident #3 and administered Resident #3 the medications. On 10/29/24 at 1:26 PM, LPN #1 indicated that other staff occasionally help with passing medications. She indicated that it's important for the residents to receive the right medication. She indicated that the nurse that's pulling the medication should be the one giving the medication to ensure the resident receives the correct medications. A review of Resident #3's Medication Audit Report dated 10/29/2024 indicated Resident #3 received his 8:00 AM medications at 11:14 AM and 11:19 AM. On 10/29/24 at 2:13 PM, the Director of Nurse (DON) indicated that the 8:00 AM medications should be given between 7:00 AM and 9:00 AM. She indicated the nurse that pulls the medications should be the nurse that administers the medication to the resident. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A policy titled Administering Oral Medication indicated that the purpose of the procedure for medication guidelines is for the safe administration of oral medications.

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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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37634 Based on observations, interviews, and record reviews it was determined that the facility failed to not administer medications that were pulled by another nurse for 1 (Resident #3) of 3 (Resident # 1, Resident #3, and Resident #4) sampled resident. The findings are: The quarterly Minimum data Set (MDS), dated [DATE], revealed Resident #3 had a Brief Interview for Mental Status (BIMS) score of 09, which indicated the resident had moderate cognitive impairment. Review of Resident #3's Care Plan revised on 05/09/2023, revealed the resident received pain medication. Interventions included administering analgesic medications as ordered by physician. On 10/29/24 at 11:10 AM Licensed Practical Nurse (LPN) 1 was observed pulling medications for Resident #3. On 10/29/24 at 11:19 AM, LPN #1 had medications in a medication cup on top of the medication cart. The Medicare Manager walked up to the medication cart and asked LPN #1 who the medications in the cup belonged to. LPN #1 informed the Medicare Manager that the medications were for Resident #3. The Medicare Nurse picked up the cup of medications and a cup of water and walked over to Resident #3 and administered Resident #3 the medications. On 10/29/24 at 11:20 AM, the Medicare Manager indicated that she knew the correct medications were in the cup for Resident #3 because LPN #1 informed her that they were correct. On 10/29/24 at 11:54 AM, Resident #3 indicated that he thinks he just got his evening meds, but he didn't know. A review of a narcotic log for pain medication indicated a Norco 5/325mg (milligram) was signed out for Resident #3 at 11:20 AM by LPN #1. A review of Resident #3's Medication audit report dated 10/29/2024 indicated that Resident #3 received his 8:00 AM medications at 11:14 AM, and 11:19 AM. On 10/29/24 at 1:26 PM, LPN #1 indicated that other staff occasionally help with passing medications. She indicated that it's important for the residents to receive the right medication. She indicated that the nurse that's pulling the medications should be the one giving the medication to ensure the resident receives the correct medications. On 10/29/24 at 2:13 PM, the Director of Nurse (DON) indicated the 8:00 AM medications should be given between 7:00 AM and 9:00 AM. She indicated that the nurse that pulls the medications should be the nurse that administers the medication to the resident. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A policy titled Administering Oral Medication indicated that the purpose of the procedure for medication guidelines is for the safe administration of oral medications.