STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045337	A. Building B. Wing	04/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Heather Manor Nursing and Rehabilitation Center	400 West 23rd Street Hope, AR 71801

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 48977 Based on observation, interview, and record review, the facility failed to treat each resident with respect and dignity, and care for each resident in a manner and in an environment that promoted the maintenance or enhancement of his or her quality of life, recognizing each resident's individuality for 2 (Residents #25 and #50) sampled residents with the potential to affect 8 Residents dependent on staff for meal assistance. The findings are: 1. Resident #25 had diagnoses of Paraplegia and Major depression disorder. A Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 03/11/2024 documented Resident #25 scored an 11 (8-12 indicates moderate cognitive impairment) on a Brief Interview for Mental Status (BIMS), and required limited assistance with eating. a. On 04/01/2024 at 12:50 PM, Certified Nursing Assistant (CNA) #2 placed a clothing protector around Resident #25's neck and voiced to the resident, Don't try to feed yourself, you are a feeder. b. On 04/01/2024 at 12:55 PM, CNA #1 set Resident 25's meal, one of the first trays to come out the kitchen, on the table in front of the resident and voiced to the resident, Wait a minute, you know someone has to help you. CNA #1 then walked away and continued serving trays to the remaining residents in the dining room. The Surveyor observed 8 staff members serving in the dining room during meal service. c. On 04/01/2024 at 01:02 PM, Resident #25 picked up a spoon from the table, attempted to get food from the plate and put it in the resident's mouth. d. On 04/01/2024 at 01:05 PM, Resident #25 asked another Surveyor to help the resident with meal service. e. On 04/01/2024 at 01:08 PM, Resident #25 asked Registered Nurse (RN) #1 if she could help the resident with meal service. RN #1 voiced to Resident #25 that she would return to help the resident. f. On 04/01/2024 at 01:10 PM, RN #1 sit next to Resident #25 and initiated assistance with meal service. (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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	g. On 04/01/2024 at 01:13 PM, the Surveyor asked CNA #1, when you placed Resident 25's meal on the table in front of the resident, what instructions did you give Resident #25? CNA #1 voiced that she instructed Resident #25 not to try to feed their self that someone would come back and help. The Surveyor asked CNA #1, if it was standard practice to place a meal on the table in front of a resident and instruct that resident not to feed themself while the resident watches other residents at other tables eat. CNA #1 did not respond to the question, but asked the Surveyor, so I should have brought the resident's plate out last? h. On 04/02/2024 at 12:35 PM, the Surveyor asked CNA #2, yesterday I heard you refer to Resident #25 as a feeder, what did you mean by that? CNA #2 stated, As a feeder, [the resident] has to be fed, [the resident] has a hard time picking up [the resident's] silverware. [The resident] basically depends on us for everything. If you are waiting on [the resident] to feed [their self], it will be all day. i. On 04/02/2024 at 12:38 PM, the Surveyor asked the Director of Nursing (DON), if it was standard practice to deliver a resident's meal, instruct [the resident] not to help [themself] with eating, and continue passing out meal trays rather than sit and assist [the resident], allowing the resident to watch other residents eat. The DON stated, No. The Surveyor asked the DON what issue this could cause for the resident. The DON stated, Dignity. The Surveyor asked the DON if it was standard practice to refer to a resident as a feeder, while having a conversation with that resident? The DON stated, No, it's a dignity thing. 2. Resident #50 had diagnoses of Vascular dementia, Transient ischemic attacks, and Chronic kidney disease. The Quarterly MDS with an ARD of 01/24/2024 documented a BIMS score of 10. a. On 04/01/2024 at 10:00 AM, the Administrator provided a survey binder with Meal Times, which documented, .07:30 AM, 12:30 PM, and 05:30 PM . b. On 04/02/2024 at 12:34 PM, Resident #50 was sitting in a wheelchair, with an apron tied around [the resident's] neck. A food tray with remains of French toast sticks with syrup, eggs, a bowl of oatmeal, two empty cranberry juices, and a partial container of milk were resting on the lowered over the bed table. The Surveyor touched the milk carton, and it was warm to the touch. Resident #50 woke up and finished drinking the container of milk and picking at egg particles. c. On 04/02/2024 at 01:30 PM, lunch had not been served on the floor and Resident #50's breakfast tray was still on the over the bed table. The Surveyor observed Resident #50 facing the window with the resident's back to the meal tray. Resident #50 was observed leaning face forward with both hands reaching back and forth pulling on the apron ties, and occasionally yanking on the apron. d. On 04/02/24 at 01:42 PM, Resident #50 rolled the wheelchair to the over the bed table and was eating pieces of egg and french toast off of the breakfast tray. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	e. On 04/02/2024 at 01:44 PM, CNA #3 walked into Resident #50's and asked if Resident #50 was still eating breakfast and would like lunch. Resident #50 said, Yes, I was just eating. The Surveyor asked what the procedure was for picking up breakfast trays and removing aprons. CNA #3 stated, Well, we come to the room and ask if they are finished. [Resident #50] is care planned that [the resident] takes longer to feed [the resident]. The Surveyor asked what time residents normally receive a breakfast tray, and how long has this tray been sitting in Resident #50's room. CNA #3 reported Resident #50 normally got a tray about 08:15 AM, and it had been 5-6.5 hours. CNA #3 said she was not sure when it comes to food if it is still safe to eat. The Surveyor asked if Resident #50 had been drinking the milk that was on the tray, would that be too long. CNA #3 stated, Yeah, that is too long. CNA #3 told the Surveyor they felt the food was safe as long as Resident #50 was not drinking the milk or eating cheese and dairy products. f. On 04/03/2024 at 09:00 AM, the Director of Nursing (DON) was asked what process staff was expected to use for picking up meal trays, removing aprons, and how long is too long for meal trays to remain in the Resident ' s rooms. The DON told the Surveyor that ideally trays should be picked up after breakfast but told the Surveyor they have some residents that take longer for meals. The Surveyor asked how long was considered too long to consider food safe for residents to eat. The DON said, Well and did not finish the statement. The DON confirmed there is not a policy on the serving of meals. g. On 04/02/2024 at 01:50 PM, the Surveyor was provided with a policy titled Resident Rights documenting, . Each and every resident in this facility has the right to: .To be treated with consideration, respect and full recognition of dignity and individuality . 47916

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. 47916 Based on observation, interview, and record review, the facility failed to ensure 2 (Residents #12 and #23) were not served dislikes in the dining area to prevent weight loss or nutritional deficits. This failed practice had the potential to affect 79 residents that eat meals from the kitchen. The findings are: 1. Resident #12 had diagnoses of Congestive heart failure, Acute respiratory failure with hypoxia, and Anemia. The Annual Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 01/18/2024 documented a Brief Interview for Mental Status (BIMS) score of 9 (8-12 suggest mildly impaired). Resident #12 required supervision or touch assistance for meals. a. A Care Plan for Resident #12 (Revision on: 12/07/2021) documented, .Offer substitutes for foods not eaten . b. On 04/01/2024 at 01:09 PM, Resident #12 was complaining loudly to the Dietary Manager (DM) that the resident does not eat this stuff, while pointing to chicken alfredo on Resident #12's plate. Resident #12's meal slip documented Resident #12 disliked chicken spaghetti. c. On 04/01/2024 at 01:11 PM, the Surveyor asked the DM to review Residents #12's meal slip, and the DM identified chicken spaghetti as a dislike. During the interview the DM was asked other than the shape of the pasta to describe in what way the chicken alfredo was different from chicken spaghetti. While the DM was thinking about it, the Surveyor asked if the chicken spaghetti had a red sauce or an alfredo sauce and the DM confirmed they use an alfredo sauce, and chicken alfredo is made with very similar ingredients to chicken spaghetti. 2. Resident #23 had diagnoses of Acute on chronic congestive heart failure, Type II diabetes mellitus, and Cerebral infarction. The MDS with an ARD of 03/22/2024 documented a BIMS score of 13 (13-15 suggest cognitively intact). Resident #23 required set up assistance for meals. a. On 04/01/2024 at 01:17 PM, Resident #23 was telling Registered Nurse (RN) #1 that the resident was tired of getting this slop. Staff offered to get a food alternative and Resident #23 told RN #1 the resident was just going to their room. Resident #23's meal slip documented a dislike for lettuce. Resident #23's plate had a roast beef sandwich, and lettuce salad with dressing. b. On 04/01/2024 at 01:19 PM, the DM was asked to look at Resident #23's meal slip. She told the Surveyor that Resident #23 is one of three that frequently complain about the food. The DM looked at the meal slip and said, I see, [the resident] was served lettuce and that is a dislike. The Surveyor asked what procedures are in place to prevent residents receiving dislikes. The DM told the Surveyor that there are two people that see the plates before they leave the kitchen, and they should correct the meals before serving. The DM told the Surveyor that the CNAs that serve the meals should notify the kitchen if someone receives dislikes so the plate can be corrected. c. On 04/03/2024 at 09:00 AM, the Director of Nursing (DON) confirmed there is not a policy on the serving of meals.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 48977 Based on observation and interview, the facility failed to ensure combustible equipment was safely locked away from residents who wonder and/or self-propel throughout the facility. This failed practice had the potential to affect 8 (Residents #30, #68, #4, #50, #23, #28, #81, and #19) sampled residents of 38 residents who could self-propel in a wheelchair. The findings are: On 04/01/2024 at 09:05 AM, the Surveyor opened a door labeled Oxygen at the end of 200 Hall and found portable oxygen tanks, supplies, and other equipment inside. A second Surveyor arrived and observed the Surveyor standing with the door open. On 04/01/2024 at 09:14 AM, the Surveyor opened a door labeled Oxygen at the end of 600 Hall and found portable oxygen tanks, supplies, and other equipment inside. On 04/01/2024 at 09:07 AM, the Surveyor asked the Admission Coordinator if the door should be locked, referring to the door labeled Oxygen at the end of 200 Hall. The Admission Coordinator stated, Yes ma'am, it should be locked. On 04/01/2024 at 09:15 AM, the Surveyor asked Licensed Practical Nurse (LPN) #3, if the door should be locked, referring to door labeled Oxygen at the end of the 600 Hall. LPN #3 stated, It just wasn't closed all the way. On 04/02/2024 at 12:38 PM, the Surveyor asked the Director of Nursing (DON), if rooms containing oxygen tanks and other equipment should be locked. The DON stated, Yes, they should. The Surveyor asked why is it important that type of equipment be behind locked doors. The DON stated, So they don't get in and mess with it. On 04/02/2024 at 2:00 PM, the DON informed the Surveyor the facility did not have a policy on Accidents and Hazards.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. 48977 Based on observation, interview, and record review, the facility failed to ensure humidifier bottles and nasal cannula tubing were dated and stored in a safe and sanitary manner to prevent infection for 2 (Resident #50 and #78) of 3 sampled residents with the potential to affect 5 residents on the 200 Hall and 2 on the 400 hall. The findings are: 1. Resident #78 had diagnoses of Abnormal findings of lung field and Cerebral infarction. Resident #78 had a Physicians Order dated 03/31/24 for oxygen therapy at 1 liter via nasal cannula and was changed to 3 liters on 04/03/2024. a. On 04/01/2024 at 11:15 AM, Resident #78 was lying in bed receiving humified oxygen via nasal cannula at 1 liter per minute. The Surveyor noted the humidifier bottle was not dated. b. On 04/01/2024 at 11:20 AM, the Surveyor asked Registered Nurse (RN) #1 while at Resident #78's bedside, Does that (humidifier) water bottle have a date? RN#1 stated, It is not dated. The Surveyor asked, Is the tubing dated? RN #1 stated, No it is not dated either. c. On 04/02/2024 at 12:38 PM, the Surveyor asked the Director of Nursing (DON), Should water used for oxygen therapy be dated? The DON stated, Yes. The Surveyor asked, What does the date indicate? The DON stated, When it was opened. 2. Resident #50 had diagnoses of Vascular dementia, Transient ischemic attacks, and Chronic kidney disease. The Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 01/24/2024 suggested a Brief Interview for Mental Status (BIMS) score of 10 (8-12 indicates moderate cognitive impairment). a. A Physicians Order: Dated 03/15/2024 noted Resident #50 was to receive Oxygen at 2 liters per minute via nasal cannula as needed for oxygen saturations less than 90%. b. A Care Plan with a revision date of 07/23/2024 documented Resident #50 had oxygen therapy as needed and was to be .monitored for signs and symptoms of respiratory distress and report to the Medical Doctor as needed. Resident #50 is ambulatory at times in room and was to be provided extension tubing or portable oxygen apparatus. c. On 04/01/2024 at 10:23 AM, Resident #50 was standing up transferring from wheelchair to bed, a fall mat was on the left side of the bed and an oxygen concentrator was turned off. The humidifier bottle was not dated, and the nasal cannula tubing was hanging behind the concentrator to the floor. No storage bag was available. d. On 04/02/2024 at 07:57 AM, the Surveyor observed an undated humidifier bottle and nasal cannula tubing resting over the back of the concentrator. No storage bag for the tubing was noted in the room. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	e. On 04/02/2024 at 12:50 PM, the Surveyor asked Licensed Practical Nurse (LPN) #3 if Resident #50's oxygen had been discontinued as the concentrator was not in the room, and to explain the procedure for caring for equipment on a resident with as needed orders. LPN #3 told the Surveyor that Resident #50 gets as needed oxygen and the humidifier bottle and nasal cannula tubing should be dated, and the tubing stored when not in use. The Surveyor asked why the facility expects the nasal cannula to be stored when it is not in use. LPN #3 told the Surveyor to keep the germs away, and to keep it sanitary. LPN #3 was not sure where the concentrator was, suspects it is receiving maintenance, and confirmed Resident #50 has as needed oxygen orders. f. On 04/02/2024 at 02:00 PM, the DON was asked what is the procedure for caring for oxygen tubing and equipment. The DON confirmed that oxygen tubing and humidified water bottles should be dated, and the tubing stored in a plastic bag when it is not in use. The DON was asked if it was appropriate for staff to leave oxygen tubing resting over the concentrator touching the floor. The DON said it was not okay because it is unclean. g. On 04/03/2024 at 11:56 AM, the Surveyor was provided a copy of an Inservice Education Report documenting, .Please ensure that every Sunday Night/Monday morning that oxygen tubing, updraft tubing is changed . 47916

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F 0761 Level of Harm - Minimal harm or potential for actual harm 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. 48977 Based on observation, interview and record review, the facility failed to ensure the storage container used to store controlled medications requiring refrigeration was permanently affixed. The findings are: On 04/01/2024 at 10:15 AM, during observation of medication room with Licensed Practical Nurse (LPN) #1, LPN #1 removed the storage box used to store refrigerated controlled medications and placed the storage box on the counter. The Surveyor instructed LPN #1 to open the storage box for an inventory of what was contained inside. The Surveyor noted that the storage box contained 3 syringes of Lorazepam 2 mg/ml (milligram/milliliter) for emergency use and prescribed Lorazepam 0.25ml syringes. On 04/01/2024 at 10:20 AM, the Surveyor asked LPN #1 if the storage box was used to store refrigerated controlled medication permanently affixed. LPN #1 voiced that it was not attached and to his knowledge it was only required to be under 2 locks. On 04/02/2024 at 12:38 PM, the Surveyor asked the Director of Nursing (DON), what halls does the front medication room store medications for? The DON stated, 100, partial 200, 300, and 400 Halls. The Surveyor asked if the storage box used to store controlled medication that require refrigeration was permanently affixed. The DON stated, No, but it's behind two locks. On 04/02/2024 at 01:50 PM, a policy titled, Medication Ordering and Receiving from Pharmacy documented, . G. Medications listed in Schedules II, III, IV, and V are stored under double lock. Alternatively, in a unit dose system, Schedule III, IV, and V medications may be distributed with other medications throughout the cart, while the schedule II medications are kept under double lock, attached to a permanently affixed wall .

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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. 49413 Based on observation, investigation, and record review, the facility failed to ensure that hand sanitation was performed while preparing food, that kitchen equipment was clean and properly maintained, that food was in useable condition, that food was stored at least 6 off the floor, and that dirty dishes were properly placed in the dishwasher. The findings are as follows: 1. On 04/03/2024 at 12:08 PM, Dietary Aide #1 placed her hands under her apron, retrieved her glasses, and without washing her hands continued to set food up for serving. 2. On 04/03/2024 at 12:30 PM, the seal on the Ice Machine on the right, between the vent and ice container, was held in place by tape. 3. On 04/03/2024 at 12:38 PM, the following observations were made: a) The walk-in freezer contained 12 wheat sub rolls and 60 white sub rolls on the top shelf with ice particles inside the bag and surrounding the rolls. b) Ice was frozen to the side of the freezer door. The Dietary Manager (DM) confirmed she should scrap the ice off because it interferes with the seal of the freezer. 4. On 04/03/2024 at 12:39 PM, the vent above the door leading outside had a buildup of a black fuzzy substance that would wave as air passed by. The DM confirmed the air flow vent needed to be cleaned. On 04/03/2024 at 10:57 PM, the Administrator entered the kitchen to take a photo of the ice machine to order the broken seal. At that time the Administrator confirmed Maintenance was to clean the air vent. 5. On 04/03/2024 at 12:41 PM, Dietary Aide #2 placed dirty dishes into the dishwasher from the clean dish side. Dietary Aide #2 confirmed that could contaminate the clean dishes and the countertop where the dirty dishes were located. 6. On 04/03/2024 at 01:04 PM, a rubber spatula laid on the food preparation table by the serving table had numerous pieces of rubber missing from around the edges. The Dietary Manager confirmed the concern of bits of rubber breaking off the spatula into the food. 7. On 04/03/2024 at 01:08 PM, Dietary Aide #3 had her hand resting on the inside of a meal tray lid, then placed the lid on top of meal tray. 8. On 04/03/2024 at 01:09 PM, Dietary Aide #1 had her hand touching the inside part of a bowl lid, then placed the lid on the bowl to be sent to a residents' room as part of the meal. 9. On 04/03/2024 at 1:22 PM, the following observations were made in the dry food storage area: (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	a) 1 bag of 16-ounce tortilla chips was open on the storage shelf and not sealed. b) 1 bag of 16-ounce tortilla chips was on the storage shelf with an expiration date of 03-21-2024. c) 1 box of 25-pound parboiled rice was open on the storage shelf. d) 1 box of 25-pound graham crackers was open and did not have an open date. e) 1 bottle of 32 fluid ounce lemon juice was on the storage shelf opened with the directions stating to refrigerate after opening. f) 1 bottle of 32 fluid ounce lemon juice was on the storage shelf opened without an open date. g) One 5-pound bucket of peanut butter was on the storage shelf opened without an open date. h) One 11-pound bucket of chocolate fudge icing did not have an open date and the icing was adhered to the outside container around the lid and down the side. The DM confirmed the concern was the icing going bad and rodents getting into the icing. i) 1 container containing corn bread granules failed to have the cover sealed. j) 1 tray containing 7 loaves of 24-ounce white bread was sitting in direct contact with the floor. The DM confirmed the bread delivery person places the bread trays directly on the floor by the kitchen back entrance door and that the bread is contaminated which affects the residents. 10. On 04/03/2024 at 1:45 PM, the fire alarm pull station by the kitchen back door entrance had a black sticky substance all over the pull alarm box. The DM confirmed it was dirty. 11. On 04/03/2024 at 1:50 PM, the spice storage area had 3 spice containers that were not completely closed: two 20-ounce garlic powder containers and one 16-ounce whole celery seed container. 12. On 04/03/2024 at 02:05 PM, the front entrance refrigerator contained 2 boiled eggs in a bowl with a date of 03-18-2024. 13. On 04/03/2024 at 10:25 AM, the back entrance door was not fully sealed. The DM confirmed that the Administrator was notified. At 10:58 AM, the Administrator confirmed that Maintenance was notified and was working on the situation. 14. On 04/03/2024 at 07:14 AM, a red cleaning bucket with brown murky water was sitting on the lid of the deep fryer. Dietary Aide #2 placed a used cloth inside the bucket. 15. On 04/03/2024 at 07:20 AM, a dirty cleaning cloth was left next to the coffee pot and another on the food preparation table in the corridor connecting the kitchen and dry food storage area. 16. On 04/03/2024 at 07:25 AM, 2 bags of 1.75-ounce individual serving cookies were opened with the cookies laying on the bottom of the bin. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	17. On 04/03/2024 at 07:28 AM, the following delivered food items were in direct contact with the floor: a) 2 cardboard boxes containing 36 cans each of soda b) 1 cardboard box containing 36 cans of diet soda c) 1 cardboard box containing tomatoes with zucchini d) 1 cardboard box containing thickened water with a hint of lemon e) 1 cardboard box containing 96 - 0.75-ounce individual serving cups of corn flakes f) 1 cardboard box containing 144 - 1.76-ounce glazed honey buns g) 1 cardboard box containing 64 - 1-ounce white cheddar snack product 18. On 04/03/2024 at 07:30 AM, a cardboard box contained paper pan liners had the front left corner torn and was held in an upward position exposing that corner. At 10:20 AM, the DM confirmed a concern did not exist due to the DM would grab the pan liners from the middle of the box. The Surveyor observed a Dietary Aide had taken the top sheet two different times. 19. On 04/03/2024 at 07:36 AM, the steam table contained murky looking water with a white foam substance floating on the top; the water level did not reach the bottom of the pans containing the resident's meal. Dietary Aide #2 stated, I was running late and didn't empty the water last night. 20. On 04/03/2024 at 11:57 AM, the 4 stove hood vents were covered in a black sticky looking substance. The DM confirmed the vents looked rusted and needed to be repainted. 21. On 04/03/2024 at 11:56 AM, the Administrator provided a policy titled, Dry Food Storage which documented, .Purpose: To ensure dry food is stored in a safe, sanitary manner to ensure the best food quality .Procedure . Food will be stored at least 6 [inches] off floor to provide ease in cleaning floors .Food will be stored on shelves that are cleanable and allow for fair circulation .Opened food items will be stored in clean, dry, sealed containers with contents noted and opened on dates . 22. On 04/03/2024 at 11:56 AM, the Administrator provided a policy titled, Cold Storage Areas, which stated, . Policy: It is the policy to store cold food under safe and sanitary conditions . Purpose: Refrigerators and freezers are designed to keep food cold enough to prevent or slow the growth of bacteria as well as preserve the freshness and quality of foods. Units work effectively and efficiently when maintained, cleaned, and serviced . Procedure .Inspect refrigerators and freezers regularly for leaks, frozen areas, and dust on compressor units. Report problems/concerns according to the facility's preventive maintenance program . Always keep refrigerator and freezer doors closed, unless in immediate use, to minimize temperature fluctuations . Date, label, and properly secure all products removed from original containers with all items labeled stating the contents inside, the date opened and the appropriate use by date . (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045337	A. Building B. Wing	04/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Heather Manor Nursing and Rehabilitation Center	400 West 23rd Street Hope, AR 71801

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

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	23. On 04/03/2024 at 11:56 AM, the Administrator provided a policy titled, Food Storage which stated, . Policy: Food is stored and prepared in clean safe sanitary manner that will comply with state and federal guidelines . Purpose: to minimize contamination and bacteria . Procedure . Food is stored at least 6 from floor and 18 from ceiling . All food not in original containers are to be labeled and dated and stored in NSF [National Sanitation Foundation] approved containers .

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045337	A. Building B. Wing	04/04/2024

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 48977 Based on observation, interview and record review, the facility failed to ensure intravenous medications were administered in a safe and non-contaminated manner for 1 (Resident #68) sampled resident. This failed practice had the potential to cause further infection directly into blood stream. The findings are: Resident #68 had diagnoses of Osteomyelitis and Pressure ulcer to sacral region. Resident #68 was receiving Vancomycin (an antibiotic) 1250mg (milligram) every 8 hours intravenous, Ceftriaxone (an antibiotic) 2g (gram) twice a day intravenous and was on contact isolation due to Methicillin-resistant Staphylococcus Aureus in wound. According to a Quarterly Minimum Data Set with Assessment Reference Date of 03/11/2024, Resident #68 had Intravenous (IV) Access while a Resident. On 04/03/2024 at 01:09 PM, the Surveyor observed Licensed Practical Nurse (LPN) #2 putting on a gown and gloves prior to entering Resident #68's room. LPN #2 uncapped the Peripherally Inserted Central Catheter (PICC) lumen, uncapped a 10cc (cubic centimeter) normal saline flush and tossed the caps for the lumen and saline on Resident #68's bed. LPN #2 pushed 5cc of normal saline, connected the IV (intravenous) tubing, and initiated infusion. LPN #2 recapped the remaining 5cc of normal saline. On 04/03/2024 at 01:39 PM, the Surveyor observed LPN #2 put on a gown and gloves, then disconnect Resident #68's IV tubing. LPN #2 then uncapped the previously recapped normal saline and flushed the remaining 5cc of normal saline then a heparin flush (used to keep the IV open). LPN #2 exited the room to retrieve a cap for the PICC lumen and returned to cap lumen without putting on gown and gloves. On 04/03/2024 at 01:45 PM, the Surveyor asked LPN #2, if that was the same normal saline flush used before she started the infusion. LPN #2 voiced that it was the same normal saline flush. The Surveyor asked what she did with the cap after she removed it the first time. LPN #2 stated, I probably threw it on the counter or bed; therefore, it was not sterile or clean anymore. The Surveyor asked why she didn't get another flush considering she was dealing with a PICC line. LPN #2 voiced that she was trying to save on supplies. The Surveyor asked what could be a negative outcome of attaching a contaminated flush to the lumen. LPN #2 stated, Further infection. The Surveyor asked LPN #2, when you capped the lumen after the infusion was complete, did you touch the tip? LPN #2 stated, I touched, but I don't think I touched the end, and I didn't have on gloves. The Surveyor asked when a resident is in contact isolation what should you have on? LPN #2 did not answer the question, but stated, In a hurry, I guess I forgot. On 04/03/2024 at 01:50 PM, the Surveyor asked the Director of Nursing (DON), when a Resident is in contact isolation, what Personal Protective Equipment (PPE) should staff put on prior to contact? The DON stated, Gown and gloves. The Surveyor asked why it is important for staff to wear proper PPE when providing care. The DON stated, To protect everyone. The Surveyor asked if a staff member had a 10cc syringe, pushed 5cc to flush a PICC line prior to infusion, then recapped the syringe, what should be done to flush the PICC line after the infusion is complete? The DON stated, She should throw it away and get a new one. The Surveyor asked what could be a negative outcome of not doing that. The DON stated, Infection. (continued on next page)

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	045337	A. Building B. Wing	04/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Heather Manor Nursing and Rehabilitation Center	400 West 23rd Street Hope, AR 71801

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 04/03/2024 at 01:50 PM, the DON voiced that the facility did not have a policy on PICC lines. On 04/01/2024 at 10:00 AM, a policy titled Isolation Precautions, Categories of documented, .B. Contact .c. Gloves and Handwashing 1. Wear gloves (clean, nonsterile) when entering the room . d. Gown 1. Wear a disposable gown upon entering the Contact Precautions room .