STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045340	A. Building B. Wing	08/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Russellville Nursing and Rehabilitation Center	215 South Portland Avenue Russellville, AR 72801

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. 51064 Based on observation, interview, and record review, the facility failed to provide a safe, clean, homelike environment for 1 (Resident #44) of 1 resident regarding linen changes, 2 (Resident #15 and #44) of 2 residents regarding plaster cracking, and 43 out of 43 residents who use the 100 Hall bath. 1. On 08/19/2024 at 11:36 AM, the surveyor noted Resident #44's bed to be unmade, covers pulled back, and bottom linens appeared soiled with two large, orange-colored spots on fitted sheet. The surveyor noted an orange colored spot on the pillowcase on pillow at the head of the bed. the surveyor noted multiple flies around the resident's bed and a urine odor present. The surveyor made additional observation of unmade bed with soiled linens on 08/20/2024 at 11:58 PM. The surveyor interviewed Certified Nursing Assistant (CNA) #5 and asked when Resident #44's bed linens were last changed, CNA #5 stated on shower days and when the resident wants the linens changed. When asked why the resident's linens were not changed when visibly soiled, CNA #5 stated I don't know. 2. On 08/19/2024 at 11:50 AM, the surveyor noted the sink in Resident #44 and Resident #15's personal bathroom to have cracks in plaster between wall and sink with large piece of plaster missing. The surveyor made additional observation of the sink with cracks in plaster between wall and sink with large piece of plaster missing on 08/20/2024. When interviewed the Maintenance Supervisor stated, I didn't even know about this sink. 3. On 08/19/2024 at 1:04 PM, the whirlpool tub in the bath room on 100 Hall was noted to have what appeared to be feces present. The surveyor made an additional observation of apparent fecal matter in whirlpool on 08/20/2024 at 9:56 AM. When interviewed CNA #4 stated housekeeping is responsible for cleaning baths. Housekeeper #6 was interviewed and stated baths are cleaned every day, and that no dirt or bodily material should be present following daily cleaning.

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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. 51064 Based on observation, interview, and record review, the facility failed to follow a grievance policy signed by the facility and resident upon resident admission to include completing a grievance form and prompt resolution of grievance for 1 (Resident #16) of 1 sampled resident. On 08/19/2024 at 10:30 AM, Resident #16 reported a lost tablet. A family member at bedside reported the tablet purchased by family was lost or stolen while the resident was in the facility. The family member reported Administration was made aware, and an investigation was supposed to be initiated. On 08/20/2024 at 2:44 PM, the Assistant Director of Nursing (ADON) was interviewed regarding Resident #16's family member reporting the missing tablet to the Administrator. When asked if tablet was found, the ADON stated she was never notified. On 08/20/2024 at 2:44 PM, the Administrator was interviewed and asked if Resident #16's tablet was reported missing. He stated he could not recall an incident where tablet had been reported missing. On 08/20/2024 at 2:50 PM, the Assistant Director of Nursing stated that yes, the resident and resident family had reported to the Administrator the tablet was missing On 08/20/2024 at 3:00 PM, the Administrator stated he did recall a family member stating a resident's tablet had been missing, and that he had requested information on the tablet so it could be located or replaced, however no information was received. When asked if a grievance report was completed regarding the incident the Administrator stated he did not interpret this as a grievance. On 08/20/2024 at 3:30 PM, the surveyor called the family representative who stated the tablet was provided by family and was lost or stolen while Resident #16 was in the facility. When asked if facility administration had requested information regarding tablet so it could be located or replaced, the family representative stated no information had been requested. When asked if the facility offered any restitution for missing property, the family representative stated no restitution had been offered. On 08/20/2024, review of a document titled, Grievance Policy and Procedure. dated 11/22/2016, provided by facility showed the resident has the right to voice grievances without discrimination or reprisal, and the facility must make prompt efforts to resolve grievances. The facility will make all efforts to resolve the grievance promptly. The expected timeframe for resolution of grievances is 5 business days.

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident when there is a significant change in condition 43262 Based on record review and interview, it was determined the facility failed to ensure a comprehensive Minimum Data Set (MDS) assessment was completed within 14 days after a significant change was identified to facilitate the ability to determine if any changes in care were necessary for 1 (Residents #58) sampled resident admitted to hospice care. The findings are: A review of an Admission Record indicated the facility admitted Resident # 58 with diagnoses that included hypertensive heart disease with heart failure and Alzheimer's disease. A review of the Order Summary Report, dated 03/16/2024, revealed an order reading, Admit to: Long Term Care/ Hospice. The Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 05/13/2024 revealed in Section O0110, Special Treatments, Procedures, and Programs, K1. Hospice care While a resident? Yes. Review of Resident # 58's Care Plan, initiated 03/04/2024, revealed the resident was admitted to [company name] hospice on 03/04/2024 for hypertensive heart disease with heart failure. Interventions included 2 hospice aides to come 5 times/week, Registered Nurse (RN) two times a week and PRN (as needed), weather permitting and on call for holidays. During an interview on 08/22/2024 at 8:06 AM, the MDS Coordinator said she uses the RAI (Resident Assessment Instrument) Manual as the criteria for a significant change such as a decline in 2 areas like weight loss, a decline in ADLs (Activities of Daily Living) or going on/coming off hospice. The MDS Coordinator said she is familiar with Resident #58 and realized she overlooked doing a significant change MDS when resident was admitted on hospice.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49596 51064 Based on observation, interview, and record review, the facility failed to ensure an accepted power source was used for medical equipment to prevent the potential for fire hazards. The oxygen concentrator and pacemaker equipment were plugged into a small white 6 outlet power strip hanging on the wall behind the head of the bed of Resident #4. The facility failed to provide an environment that is free from accidents and hazards affecting 1 (Resident #12) resident. The findings are: 1. On 8/19/24 a physician orders indicated oxygen was to be continuous at 3 liters per minute utilizing a nasal cannula and every Thursday a nurse was to check the Heart Monitor which will be checked between the hours of 2-4 am every night shift on Thursdays by St [NAME] Medical phone. a. On 8/19/24 at 11:44 AM, the surveyor observed a small 6 outlet power strip hanging on the wall above the head of Resident #4. The resident's oxygen concentrator and pacemaker equipment were plugged into two of the outlets along with a cell phone charger. b. On 08/20/24 at 7:23 AM, the surveyor observed a small 6 outlet power strip hanging on the wall above the head of Resident #4. The resident's oxygen concentrator and pacemaker equipment were plugged into two of the outlets along with a cell phone charger. c. On 08/20/24 at 8:12 AM, the surveyor observed the back of the power strip, and it does not have one of the two numbers, (UL1363 or UL1363A as identified by Life Safety surveyor) accepted medical grade power strips. d. On 8/21/24 at 9:49 AM, during an interview in the resident's room, with the Administrator, he said the power strip was a concern due to the medical equipment being plugged in to it because medical equipment cannot be plugged into this type of power strip. 2. On 08/19/2024 at 11:35 AM, the surveyor was told by Resident #12 that the toilet in the resident's bathroom moves when resident's roommate uses the bathroom, and after it is moved it is difficult for the resident to use the bathroom. Resident #12 reported notifying staff and administration, but it had not been fixed. The surveyor observed the toilet in Resident #12's bathroom was easily moved several inches from its original location. Resident #12 reported the toilet had been like that for months. a. The surveyor made an additional observation of the toilet moved from its original location on 08/20/2024 at 11:45. b. During an interview on 08/20/2024 at 1:30 PM the Maintenance Supervisor stated Yeah, I know about this toilet, the people who built this home shouldn't have put tile in the bathroom. I can caulk it if I need to. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. On 08/19/2024 at 11:37 AM, the surveyor noted a small white pipe sticking out of Resident#47's wall, the pipe was hollow with no contents inside. The resident's walker was placed in front of pipe. The surveyor made an additional observation of pipe on 08/20/2024 at 12:00 PM. a. On 08/20/2024 at 1:30 PM the Maintenance Supervisor stated the pipe was in place to move television to other side of wall. When asked why the television had not yet been moved, the Maintenance Supervisor stated, I am not sure. When asked if there were plans to move the television soon, the Maintenance Supervisor stated, I do not know. When asked how much of pipe appeared to be sticking out from wall, the Maintenance Supervisor said approximately 4 inches. b. On 08/20/2024 at 1:50 PM, Certified Nursing Assistance (CNA) #4 was asked why the pipe was in wall, CNA #4 stated I think because of the TV. When asked how long the pipe had been present CNA #4 stated I do not know. When asked why the pipe should not be sticking out of the wall in front of where resident places their walker CNA #4 stated, Because it could tear skin. It really should be capped.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. 43262 Based on observations, interviews, record reviews, and facility policy review, the facility failed to provide appropriate treatment and services to prevent complications from enteral feedings for 1 (Resident #63) of 1 resident observed during supplemental feeding via percutaneous endoscopic gastrostomy (PEG) tube. Specifically, the facility failed to ensure placement of PEG tube before enteral feeding and flush. The findings include: A review of an Admission Record indicated the facility admitted Resident #63 with diagnoses that included gastroparesis, severe protein-calorie malnutrition, and adult failure to thrive. The annual Minimum Data Set (MDS) with an Assessment Reference Date (ARD) 07/01/2024 revealed in Section K0100, Swallowing Disorder: C. Coughing or choking during meals or when swallowing medications and D. Complaints of difficulty or pain when swallowing .K0520. Nutritional Approaches: B. Feeding tube (e.g. , nasogastric or abdominal (PEG) while a resident: Yes. Review of Resident #63's Care Plan, initiated 10/30/2023, revealed the resident has a nutritional problem or potential nutritional problem related to gastroparesis, severe protein-calorie malnutrition, and adult failure to thrive. Review of a Medication Administration Record (MAR): revealed a physician's order (PO) dated 05/09/24 revealed Resident #63 was to receive enteral feeding two times a day, [brand name] 120cc (cubic centimeter) via PEG tube, flush with H20 (water). On 08/20/2024 at 05:12 AM, Licensed Practical Nurse (LPN) # 3 was observed giving supplemental enteral feeding via PEG tube. LPN #3 performed a water flush, enteral feeding, then water flush before exiting resident's room. LPN #3 said she did not check for placement before feeding because she checked it last night before the 10 PM feeding and didn't want to have to keep Resident # 63 awake any longer than she needed to. During an interview on 8/22/2024 at 9:35 AM, the Director of Nurses (DON) said a nurse should check for placement every time before inserting flush, feeding, or medication. Review of a facility policy titled Enteral Feedings, Administration via Gastrostomy revised 11/22/2016 indicated The following equipment and Supplies may be utilized: 1. gavage bag and tubing 2. 30-60cc catheter tipped syringe 3. Stethoscope .Procedure 1. Obtain equipment 2. Explain procedure to resident 3. Check bowel sounds .1. Auscultate for air bolus over epigastric area or follow physician's orders for residual feeding as indicated.

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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. 44852 Based on observation, interview, and policy review, the facility failed to ensure food was discarded prior to the use by date, staff hands were washed between clean and dirty tasks and that meals were served in a manner as to not promote cross contamination for 80 residents who receive their meal from one of one kitchen. The findings are: On 08/19/24 at 10:35 AM, a large plastic container of soup was observed with a use by date of 8/18/24. A large plastic container, approximately 1/3 full of sliced tomatoes, had a use by date of 08/16/24. A large plastic container, approximately 1/4 full of sliced onions, was observed with a use by date of 8/16/24. On 08/19/24 at 10:43 AM, a tray containing four 4-ounce glasses of orange juice, one 4-ounce glass of tomato juice, and one 8-ounce glass of tea was observed on the middle shelf of the 2-door refrigerator. The tray and the individual glasses were not labeled with a date. On 08/19/24 the refrigerator was observed to contain no interior thermometer. On 08/20/24 at 11:25 AM, Dietary Employee #1 was observed to wash her hands prior to obtaining a steam table pan, a can of cooking spray, and handling a scoop. Employee then applied gloves to contaminated hands. On 08/20/24 at 11:46 AM, Dietary Employee #1 was observed to reach for a divided plate. Contaminated hands/fingers were placed into the interior of the plate where the food was placed for serving. This practice was observed on 3 occasions. On 08/20/24 at 11:50 AM, Dietary Employee #2 was observed as she placed the insulated dome over each lunch plate. Contaminated hands were placed inside the dome prior to placing it on top of the plate. On 08/22/24 08:19 AM, the Administrator reported the facility does not have a policy on hand washing specific to the kitchen. The policy titled Handwashing/Hand Hygiene indicated the facility considers hand hygiene as the primary means to prevent the spread of infection. The policy indicated all employees will follow the handwashing/hand hygiene procedures to help prevent the spread of infections to other personnel, residents, and visitors. On 08/22/24 at 08:30 AM, a review of the facility food storage policy revealed all food not stored in original containers will be labeled and dated and stored in approved containers. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 08/22/24 at 10:15 AM, the Dietary Manager was asked when hands should be washed when working in the kitchen. The Dietary Manager reported that hands should be washed before moving from one task to the next, and before applying gloves. When asked how dishes should be handled when serving, she identified the need to handle a dish, glass, etc. ensuring hands do not go inside the dish where liquid or food comes into contact with the dish. The Dietary Manager explained that items being put into the refrigerator/freezer should be covered and dated with the date of being placed in the refrigerator and the use by date. When asked why this practice is important the Dietary Manager described how it is important as to not give a resident spoiled food which could result in illness.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 43262 49596 51064 Based on observation, record review, and interview, it was determined that the facility failed to ensure staff followed isolation precautions including the appropriate use of personal protective equipment (PPE) prior to high contact resident care, to reduce transmission of resistance organisms for 1 (Resident #63) of 1 sampled resident observed during supplemental feeding via percutaneous endoscopic gastrostomy (PEG) tube. Specifically, the facility failed to ensure a gown was worn before a supplemental PEG tube feeding and flush and failed to ensure used personal protective equipment (PPE) was disposed of properly and the container was closed to prevent possible cross contamination to anyone passing the trash can sitting in the hallway. A review of an Admission Record indicated the facility admitted Resident # 63 with diagnoses that included gastroparesis, severe protein-calorie malnutrition, and adult failure to thrive. A review of the annual Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 07/01/2024 revealed in Section K0100. Swallowing Disorder: C. Coughing or choking during meals or when swallowing medications and D. Complaints of difficulty or pain when swallowing .K0520. Nutritional Approaches: B. Feeding tube (e.g., nasogastric or abdominal (PEG)) while a resident: Yes. Review of Physician's Order (PO), dated 03/29/24, revealed an order for Enhanced Barrier Precautions related to PEG tube every shift. Review of a PO dated 05/09/24 revealed an enteral feed order two times a day Nutren 2.0 120cc via PEG tube, flush with water. Review of Resident # 63's Care Plan, initiated 03/29/24, revealed the resident required enhanced barrier precautions related to PEG tube to reduce transmission of resistant organisms, and that staff were to use gowns and gloves during high contact resident care activities. On 08/20/24 at 05:12 AM, Licensed Practical Nurse (LPN) # 3 was observed entering Resident #63's room to administer a tube feeding. LPN #3 did not apply appropriate PPE per Enhanced Barrier Precautions (EBP) signage posted on the wall outside of the resident's room. Upon exit, LPN # 3 said she did not see the EBP signage on the wall outside resident's room and was planning on washing her hands in the bathroom behind the nurse's station, but it would probably have been better to wash them in the resident's bathroom. On 8/21/2024 at 1:45 PM, the Administrator said the facility did not have a policy on Enhanced Barrier Precautions. During an interview on 8/22/2024 at 9:35 AM, the Director of Nurses (DON) said a gown, gloves, and masks should be worn with high contact resident care.