

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045346	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/12/2025
NAME OF PROVIDER OR SUPPLIER Dierks Health and Rehab of Dierks		STREET ADDRESS, CITY, STATE, ZIP CODE 402 S Arkansas Avenue Dierks, AR 71833	

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)
<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>Based on observations, interviews, and facility policy review, the facility failed to ensure hazardous chemicals were secured and residents were prevented from having access to substances that could result in accidents or injuries, specifically failing to keep corrosive cleaning supplies out of the reach of ambulatory residents with dementia for 1 (Resident #50) of 2 sampled residents who were reviewed for accidents, resulting in one resident ingesting hydrogen peroxide cleaning solution.</p> <p>The findings include:</p> <p>The quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 3/11/2025 indicated Resident #50 had diagnoses of Alzheimer's disease, malnutrition, and depression, and had a Brief Interview for Mental Status (BIMS) score of 8 (8-12 indicates moderate cognitive impairment).</p> <p>A Nsg-I&A Progress Note, dated 11/13/2024 at 06:55 AM, indicated Resident #50 was sitting at the nurse's station and was observed with a spray bottle of disinfectant (Peroxide Multi Surface Cleanser and Disinfectant) the lid was off, the resident ingested an unknown amount of the disinfectant. The spray bottle was removed from the resident and locked in cart/housekeeping closet. Resident #50 was assessed with no signs or symptoms of injury, (name of disinfectant producer) was notified regarding the disinfectant and medical advice obtained.</p> <p>A review of Resident # 50's Care Plan dated 12/18/2024 indicated Resident #50 exhibited behavioral indicators of drinking cleaning chemicals, related to Alzheimer's disease, with a goal of care being the resident will cause no harm to self or others secondary to their behaviors. The intervention dated 11-13-24 indicated the spray bottle was removed from resident and locked in cart/housekeeping closet.</p> <p>A review of Resident #50 ' s Triage clinical report from a local hospital, dated 11/13/2024, indicated patient was an Alzheimer's patient that was thirsty and got in the cleaning cart and took one drink of peroxide multi-surface cleanser, ingesting this at 6:00 AM and vomiting once after breakfast. Resident #50 denied any complaint.</p> <p>During an interview on 06/10/2025 at 02:09 PM, the Medical Director stated they were notified of Resident #50 ingesting hydrogen peroxide cleaner, and the resident did not have any negative effects from possible ingestion of hydrogen peroxide cleaner.</p> <p>(continued on next page)</p>

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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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview by telephone on 06/10/2025 at 02:30 PM, Certified Nursing Assistant (CNA) #2 reported not being present at the time of the incident, but from what they understood, the resident did not actually swallow the cleaner, just took in mouth and spit it out. CNA #2 reported being written up for leaving the housekeeping cart out.</p> <p>A form titled Employee Memorandum was completed on 11/13/2024, indicated CNA was given a write up (reprimand) for not putting housekeeping cart back in closet after completing her shift.</p> <p>During an interview on 06/10/2025 at 02:42 PM, the Treatment Nurse reported seeing Resident #50 with a bottle of cleaning solution up to mouth. The resident took some in their mouth and then spit it out. The resident got ahold of it because the housekeeping cart was left outside the housekeeper closet door unattended. The Treatment Nurse was asked how the facility had ensured this did not happen again and stated staff made sure the cart was locked and, in the closet, carts were not left out anymore. Training was completed requiring no carts were left out.</p> <p>During an interview on 06/10/2025 at 03:04 PM, the Director of Nursing (DON) stated she was notified Resident #50 was observed with a bottle of chemicals from the housekeeper cart, unsure how much ingested, but the resident vomited. The housekeeping cart had been left out for staff to clean rooms. The DON was asked how she ensured this did not happen again and the DON stated by monitoring during rounds and observing to make carts were not left out. Carts were always to be locked and put away. The DON was asked how staff could get the cleaning supplies if they needed them and stated, the staff must get the key from the nurse. The DON stated the resident had suffered no ill effects. The resident vomited once, then was fine.</p> <p>During an interview on 6/11/20 25 at 2:35 PM, Housekeeper #11 was asked what cleaning supplies were usually kept on the housekeeping cart. Housekeeper #11 stated bio-spray (alcohol-based cleaner) was on the cart, deodorant spray, and there was no bleach on cart. Housekeeper #11 verified that the compartment on the cart containing chemicals was to be kept locked, and when the cart was not in use it was locked in the janitor's closet.</p> <p>A review of a SDS (Safety Data Sheet) indicated the cleaner Resident #50 had allegedly consumed contained a dilution of Hydrogen Peroxide of 0.78% to 3.12%. The SDS indicated if swallowed to rinse mouth, get medical attention if symptoms occur.</p> <p>A review of a policy titled Incident and Accident Policy and Procedure that indicated residents will be assessed for interventions to prevent further incidents.</p> <p>A review of an In-service Form titled, Proper Storing Chemical indicated a training was conducted by the Administrator on 11/15/2024, and indicated staff are to ensure chemicals are store in secure areas at all times when not in use.</p>		