STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045351	A. Building B. Wing	05/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Care Manor Nursing and Rehab	804 Burnett Drive Mountain Home, AR 72653

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. 44852 Based on observation, record review, and interview, the facility failed to ensure that a residents expressed preference for having their bed made was honored for one (Resident #32) sampled resident. The findings are: Review of an Order Summary Report revealed Resident #32 had diagnoses of type 2 diabetes mellitus and bipolar disorder. On the quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 04/29/24 Resident #32 received a score of 15 (13-15 indicates cognitively intact) on the Brief Interview for Mental Status (BIMS). On 05/13/24 at 02:23 PM, Resident #32 was observed sitting in his/her room adjacent to the bed. During discussion Resident #32 expressed a preference for his/her bed to be made each day. Resident #32 described feeling as if the certified nursing assistants (CNA's) ignore the unmade bed due to their being short staffed. Resident #32 reported that their bed is frequently unmade. On 05/15/24 at 08:57 AM, Resident #32 reported that his/her bed has not been made this week. When asked if he/she has requested that the bed be made the resident reported that he/she stopped asking. On 05/15/24 at 09:30 AM, Certified Nursing Assistant (CNA) #2 was asked when the resident's beds are normally made. CNA #2 described that there is no assigned time, that beds are made as they get to them, depending on the needs of the residents. She reported that bed are typically made prior to the lunch meal. CNA #2 could not recall if Resident #32's bed had been made this week, just that it should have been. CNA #2 added that some days the beds may not get made. On 05/15/24 at 09:36 AM, CNA #3 was asked when resident beds are made. CNA #3 reported that beds are made according to how busy they are. CNA #3 said that staff attempts to make the bed as soon as the resident is up for breakfast. CNA #3 expressed her belief that she made the resident's bed on Monday sometime after breakfast. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 05/16/24 by 09:28 AM, a policy entitled Homelike Environment documented, .residents are provided with a safe, clean, comfortable, and homelike environment . Policy Interpretations includes a clean, sanitary, and orderly environment. The accommodation of needs policy describes that the environment and staff behaviors and directed toward assisting the resident in maintaining and /or achieving safe independent functioning, dignity, and well-being .

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. 44852 Based on observation, interview, and record review, the facility failed to ensure that the comprehensive care plan was revised or updated for 1 (Resident #47) sampled resident. The findings are: Review of an Order Summary revealed Resident #47 had a diagnosis of malignant neoplasm of brain. On a significant change Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 03/27/2024 Resident #47 received a score of 3 (0-7 indicates severely cognitive impaired) on the Brief Interview for Mental Status. The MDS documented the resident requires substantial/maximum assistance with personal hygiene. On 05/14/2024 at 12:56 PM, a review of the residents electronic medical record revealed a physician's order for admission to Elite Hospice on 03/27/24. A nurses progresses notes recorded on 03/27/2024 at 2:48 PM recorded, [named hospice provider] RN here and resident admitted to their care. No new orders received at this time. On 05/15/2024 at 8:53 PM, a review of Resident #47's care plan identified a focus area of, The resident has a terminal diagnosis or poor prognosis related to end stage disease process and/or multiple comorbidities and has not elected hospice. On 05/16/2024 at 8:45 AM, the MDS Coordinator was asked when a resident's care plan should be updated and she stated every 3 months. When asked if there were other times when an update would be necessary the MDS coordinator replied, When changes occur. When asked if admission to hospice would be one of those time the MDS Coordinator replied, Yes. When asked to review Resident #47's care plan which documented the resident had not elected to receive hospice care the MDS Coordinator said that she had forgotten to remove the not from the focus area. The MDS Coordinator continued to describe how the system offers choices based on the care area and she didn't make the necessary changes.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. 49071 Based on interview, observation, and record review, the facility failed to ensure PRN (as needed) orders for psychotropic drugs were limited to 14 days without documentation from the attending physician or prescribing practitioner indicating their rationale in the resident's medical record for 2 (Residents #11 and #42) sampled residents that were selected for medication review. The findings are: 1. Review of Medical Diagnoses indicated Resident #11 had diagnoses of unspecified dementia, depression, cerebral infarction, and anxiety disorder. a. A significant change Minimum Data Set (MDS) with an Assessment Reference Date of 02/16/2024 indicated Resident #11 had a Brief Interview for Mental Status (BIMS) score of 99, indicating the assessment could not be completed. b. Review of a Physician's Order indicated an order dated 01/17/2024 for Clonazepam 0.5 milligram (mg) every 6 hours as needed for anxiety. c. Review of Medication Administration Records (MAR) for January ,February, March, and April of 2024 revealed that Clonazepam 0.5mg was being administered every 6 hours as needed. d. Review of the medical records and the monthly pharmacy reviews did not reveal a justification by the attending physician indicating why Resident #11 should continue Clonazepam 0.5mg every 6 hours as needed past 14 days. 2. Review of Medical Diagnoses indicated Resident #42 had diagnoses of vascular dementia, cerebral infarction, and anxiety disorder. a. A significant change Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 04/23/2024 indicated Resident #42 had a Brief Interview for Mental Status (BIMS) score of 9 (8-12 indicates moderately impaired). b. Review of a Physician's Order indicated an order dated 07/23/2023 for Ativan 1mg every 6 hours as needed for behaviors. c. Review of Medication Administration Records (MAR) for January ,February, March, April, and May of 2024 revealed that that R#42 was continuing to take Ativan 1mg every 6 hours as needed. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	d. On 05/15/2024 at 2:45 PM, the surveyor asked the Director of Nursing (DON), If the resident is receiving a PRN (as needed) psychotropic or antipsychotic medication, how is this medication monitored and how does the Interdisciplinary Team determine if the PRN medication is clinically indicated and ensure the PRN orders are consistent with PRN requirements for psychotropic and antipsychotic medications? The DON said, The Interdisciplinary Team (IDT) monitors the nurses, if they are administering the medication or if they are not taking it. The IDT then asks the nurses weekly to go over any behaviors or unusual occurrences, the IDT meets weekly, and look to see if the medication is needed to be discontinued or scheduled. They also discuss if the medication isn't working effectively, then they try an alternate therapeutic intervention. The DON was asked, When should a resident be evaluated to either continue the medication or stop the medication? The DON said, After 14 days, if they are taking it often then they need to schedule it, if they haven't taken it then they need to discontinue the medication.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46868 Based on observation, record review, and interview, the facility failed to ensure that narcotic medications were stored in a permanently affixed compartment to prevent the potential of misappropriation of resident property, that multi-use vials were dated when opened, and medications from discharged residents were appropriately accounted for and secured to prevent misappropriation of medications. The findings are: 1. On [DATE] at 5:57 PM, two surveyors entered the medication room with Licensed Practical Nurse (LPN) # 4. The facility narcotic box was easily removed from the refrigerator and placed upon the counter. LPN #4 was asked to unlock the narcotic box. Inside the box were two vials of Ativan 2 milligrams per millimeter (mg/ml) that were prescribed to a resident that had expired, as well as five syringes and two vials of Ativan injectables, 2 mg/ml, intended for facility use. a. On [DATE] at 6:15 PM, two surveyors accompanied by LPN #4 observed a vial of multi-use vial Tuberculin with no opened date, lot number 3CA26C1, expiration date ,d+[DATE]. Another vial of multi-use opened Tuberculin with no opened date Lot number 3CA18C1 with an expiration date of ,d+[DATE] was also observed. On [DATE] at 6:35 PM LPN #4 was asked who had keys to the medication room. LPN #4 stated, All the nurses. LPN # 4 was asked if the narcotic box should be able to be removed from the refrigerator. LPN #4 stated, It always has. On [DATE] at 6:48 PM, the Director of Nurses (DON) was asked if the narcotic box was able to be removed from the refrigerator. The DON stated, Yes, so the nurses can get to the medications. The DON was asked if the nurse who was responsible for the narcotic box gave the keys to another nurse without counting. The DON stated, No. The DON was asked if a resident had expired or discontinued what should happen with the medications. The DON stated, Take the tag off, count them and put them in the box. The DON was asked, if this process does not occur and medications are not locked up what could happen? The DON stated, Anything could happen such as misappropriation of medications. The DON was asked how often the narcotics were surrendered to her. The DON stated, Monthly.

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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. 49071 Based on observation, record review, and interview, the facility failed to ensure a multi-resident use glucometer was disinfected after use to prevent potential spread of infection for 1 (Resident #45) who had physician orders for capillary blood glucose (CBG) monitoring. The findings are: 1. Review of an Order Summary Report revealed Resident #45 had a diagnosis of type II diabetes mellitus and a physician's order for a fast-acting insulin to be administered according to a sliding scale (The term sliding scale refers to the progressive increase in the pre-meal or nighttime insulin dose, based on pre-defined blood glucose ranges, and is dependent on CBG monitoring). 2. On 05/15/2024 at 7:36 AM, during an observation of medication administration Licensed Practical Nurse (LPN) #1 performed a blood glucose test on Resident #45. LPN #1 took the glucometer out of a medication cart drawer and then took it to Resident #45's room and performed a CBG test (CBG testing uses a drop of blood from a finger prick to get a blood glucose reading using a blood glucose meter, or glucometer). LPN#1 then returned to the cart and replaced the glucometer without sanitizing it. 3. On 05/15/2024 at 7:54 AM, LPN #1 stated they should wipe the glucometer down with sanitizer cloth before and after using it on a resident to prevent spreading germs/infections from person to person. 4. On 05/16/2024 at 8:48 AM, the Director of Nursing (DON) said a glucometer should be cleaned before and after performing a CBG test for infection control. The DON said staff are trained to perform this test correctly during new hire orientation and are retrained annually. 5. Review of a Policy titled, Obtaining a Fingerstick Glucose Level indicated that staff were to utilize, Disinfected blood glucose meter (glucometer) with sterile lancet; or single-resident use spring-loaded device or automatic or safety type lancet .

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F 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Designate a qualified infection preventionist to be responsible for the infection prevent and control program in the nursing home. 49689 Based on record review and interview, the facility failed to ensure that an Infection Preventionist was employed by the facility during the time frame of 01/02/2024 to 02/08/2024 in which a COVID-19 outbreak occurred. The findings are: On 05/15/2024 at 10:05 AM, the Director of Nursing (DON) was asked who the Infection Preventionist (IP) during the COVID-19 outbreak in January 2024. The DON said it was another nurse but they quit either during or before the COVID-19 outbreak. The DON was asked how long the facility operated without an IP. The DON said the facility did not have an IP for roughly a month. The surveyor asked how the COVID-19 outbreak was handled with no IP. The DON reported they (the DON) looked at the policies and procedures and ensured that infection control was followed during the outbreak. The DON reported they did not have an IP license or certification. On 05/15/2024 at 2:00 PM, the Administrator was asked to describe the importance of having a trained and certified IP. The Administrator stated it is a requirement.