

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  045378	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  12/18/2024
NAME OF PROVIDER OR SUPPLIER  Woodland Hills Healthcare and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE  1320 West Braden Street Jacksonville, AR 72076	

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 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>50923</p> <p>Based on observations, record review, and interviews, it was determined the facility failed to provide snacks that were previously offered and appropriate for residents with diabetes, therefore failing to accommodate their needs, which affected the resident's quality of life for 1 (Resident #34) of 1 resident reviewed. Specifically, the facility failed to ensure Resident #34, a resident with type I diabetes, was provided snacks, other than high sugar/simple carbohydrates.</p> <p>The findings are:</p> <p>Upon review of the Admission Record, the facility admitted Resident #34 on 05/10/24 with an admitting diagnosis of type I diabetes.</p> <p>Upon review of the quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 11/26/2024, Resident #15 was assessed with a Brief Interview for Mental Status (BIMS) score of 15, (BIMS score 13-15 indicates cognitively intact). Per section GG of this MDS, the resident required supervision for ambulation and the use of a rolling walker. Resident #34 required minimal assistance with Activities of Daily Living (ADLs).</p> <p>On 12/15/24 at approximately 11:20 AM, this surveyor observed Resident #34 in the resident 's room with spouse. During an interview, Resident #34 stated, I'm a type I diabetic, and have an issue with the snacks that are offered are all high sugar content. I realize they don't have to serve all our meals as diabetic meals, but I need at least a decent snack when my sugar drops, and I'm not the only one here with diabetes.</p> <p>On 12/16/24 at 9:20 AM, an interview was conducted with the Administrator, regarding snacks offered for residents with diabetes. The Administrator stated the facility offered peanut butter with crackers, fresh fruit, and small blocks of cheese such as cheddar cheese with crackers. When asked about anything sugar free such as sugar free pudding or unsweetened apple sauce, the Administrator stated, We will at times, especially if someone requests them.</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 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 12/18/24 at 10:50 AM, Resident #34 was in the hall requesting to speak to someone. The resident's hands were shaking. Resident #34 stated, I just came from the kitchen asking for some peanut butter and crackers. I was told there was not any. I asked them what they had to offer because my blood sugar was too low, and they told me we can give you a snack cake or a fruit cup. I explained to them I prefer something with some protein in it, or a complex carbohydrate, but they said they did not have any cheese or peanut butter. This is the second time I have asked for it in the last few months, and they did not have any then either. I was told that was supposed to be one of our choices, so I do not understand why they would not have any.</p> <p>On 12/18/24 at 11:15 AM, during a concurrent observation of the kitchen area and interview, the Dietary Manager stated they were out of peanut butter and cheese but could give a snack cake. The Dietary Manager also stated they could order peanut butter and have in, possibly by the end of the week. This surveyor requested invoices for the facility's orders since mid-October. Upon review of the invoices, there was no peanut butter or peanut butter crackers ordered on any of their [vendor name] invoices from 10/22/24 through 12/13/24.</p>		

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<p>F 0554</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Allow residents to self-administer drugs if determined clinically appropriate.</p> <p>51886</p> <p>Based on observation, record review, interview, and facility policy review, the facility failed to ensure a resident without self-administration rights was not self-administering an inhaler and updraft without approval or staff presence to prevent improper usage, storage, and misappropriation of resident's own medication affecting 1 sampled (Resident #351) resident of 1 sampled.</p> <p>The findings include:</p> <p>a. A review of Resident #351 ' s Physician Orders dated 12/03/2024, revealed an order for inhaled nebulizer 1 vial every 4 hours as needed for shortness of breath or wheezing.</p> <p>b. A review of Resident #351 ' s Care Plan dated 12/03/2024, revealed Resident #351 was shown to have flare ups that caused the resident to become short of breath related to chronic obstructive pulmonary disease (COPD) diagnosis and being a current smoker. As needed medications were available for times of anxiousness.</p> <p>c. On 12/15/2024 at 11:15 AM, an inhaler was observed resting on the overbed table of Resident #351. Resident #351 stated, I was told I could keep the medication on person for when I need it.</p> <p>d. On 12/15/2024 at 3:30 PM, Resident #351 was observed alone, sitting in the resident ' s room, holding an updraft mask to [pronoun] face with fumes coming from the mask, and an inhaler remained in reach at the bedside. Licensed Practical Nurse (LPN) #1 stated LPN #2 gave Resident #351 the updraft medication. LPN #1 revealed Resident #351 would need to complete an assessment before the inhaler or updraft medication could be returned for self-administration.</p> <p>e. During an interview with the Director of Nursing (DON) on 12/15/2024 at 3:33 PM, the DON stated a nurse, or respiratory therapist was supposed to stay in the room until treatment was complete and there needed to be an order to have medication at bedside and an assessment completed to ensure residents were capable. The DON stated there had been no in-service on self-administration, updraft, and medical administration. The DON was asked to provide a policy on self-administration and a list of residents with self-administration rights.</p> <p>f. On 12/15/2024 at 4:24 PM, the DON provided a census report with a message stating they had no residents with self-administration rights. The DON also provided a policy titled Medications, Self-Administration, Self-Storage, Leave at Bedside. It revealed any resident wanting to self-administer must be assessed by a licensed nurse or respiratory therapist. It required a physician's order for any medication to be kept at the bedside. The medication administration record (MAR) would display the medications and whether they were self-administered. The care plan would inform staff where the medication was to be kept. The resident's current self-administration status would be shown on the physician's order sheet.</p> <p>g. On 12/16/2024 at 8:45 AM, the Storage of Medications guidelines were provided and revealed all medications must be stored at or near the nurse's station and locked away. The medication must be stored in a cabinet, drawer, or cart. They must have a specific contained spot for medication to prevent it from being used by someone else.</p> <p>(continued on next page)</p>		

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<p>F 0554</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>h. On 12/16/2024 at 3:03 PM, after review, there were no orders or indication if an updraft needed to be administered by the resident or staff.</p>

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<p>F 0645</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>PASARR screening for Mental disorders or Intellectual Disabilities</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 50923</p> <p>Based on interview and record review, the facility failed to complete a Level 1 Preadmission Screening and Resident Review (PASRR) for 1 (Resident #15) of 1 resident reviewed for PASRR.</p> <p>The findings are:</p> <p>Upon review of the Admission Record, Resident #15 was admitted to the facility on [DATE] with a primary diagnosis of diabetes mellitus II with unspecified complications. Resident #15 also had a diagnosis of bipolar disorder, severe, with psychotic features and panic episodes.</p> <p>Upon review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 06/14/2024, Resident #15 was assessed with a Brief Interview for Mental Status (BIMS) score of 14, (BIMS score 13-15 indicates cognitively intact). Per section GG of this MDS, the resident required extensive assistance and was dependent on staff for transfers, dressing, and bathing. They required set-up assistance for meals.</p> <p>Upon review of Resident #15's scanned documents, a Level 1 Preadmission Screening and Resident Review was not found.</p> <p>On 12/18/24 at 12:45 PM, during an interview with the Social Services Director (SSD), the SSD confirmed there was not a PASRR pre-screening determination within the chart and stated she would call [the contracted company name] to get a copy.</p> <p>On 12/18/24 at 1:36 PM, the Social Services Director notified this surveyor she had spoken with [the contracted company name] and the resident was considered a PASRR I, but the facility could not provide documentation regarding this status.</p>		

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<p>F 0661</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure necessary information is communicated to the resident, and receiving health care provider at the time of a planned discharge.</p> <p>47916</p> <p>Based on observation, record review, interview, and facility policy review, the facility failed to ensure a recapitulation, or summary, of stay upon discharge affecting 1of 1 sampled (Resident #49) resident to ensure sufficient information was given for safe care on discharge.</p> <p>Findings include:</p> <p>a. On 12/18/2024 at 11:00 AM, a review of Resident #49's medical record revealed, a 10/16/2024 discharge summary that revealed resident went home with medications.</p> <p>b. On 12/18/2024 at 11:06 AM, the Social Services Director (SSD) was asked who was responsible for the discharge summary for Resident #49. The SSD printed the Post Discharge Plan of Care and Discharging a Resident from Facility form and stated she filled those out and nursing was responsible for the discharge summary. The SSD confirmed that her documentation did not include medication reconciliation or a summary of Resident #49's care.</p> <p>c. On 12/18/2024 at 11:09 AM, the SSD was asked if there was a discharge summary for Resident #49. The SSD stated, Nursing did not put one in.</p> <p>d. On 12/18/2024 at 11:30 AM, Licensed Practical Nurse (LPN) #11 was asked who was responsible for Resident #49's discharge summary, and what should be documented. LPN #11 revealed nursing is responsible, and it should be where they went, who picked them up, medications and belongings returned. This surveyor asked LPN #11 if there should be a summary of the residents stay including reconciliation of medications. LPN #11 stated that she did not know. LPN #11 was asked for a copy of the discharge summary she put in the computer on discharge.</p> <p>e. On 12/18/2024 at 11:32 AM, LPN #11 provided Resident #49's discharge summary stating discharged home with meds, and a second discharge summary revealing that Resident #49 went home via ambulance. Meds and belongings went with resident. LPN #11 was asked if there was a summary of the resident ' s stay and medication reconciliation. LPN #11 left to check with administration.</p> <p>f. On 12/18/2024 at 11:38 AM, during an interview with the Director of Nursing (DON) and the Administrator, it was confirmed the two discharge summary notes were all that was documented for Resident #49's discharge. This surveyor asked if there should have been a summary or recapitulation of Resident #49's care. The DON was not sure. The DON and Administrator stated they would review the regulation. This surveyor requested the facility ' s discharge policy.</p> <p>g. On 12/18/2024 at 12:33 PM, a review of a policy titled Discharge/Transfer of Resident revealed sufficient information was given to the resident on discharge so that it is safe for the resident ' s aftercare.</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>47916</p> <p>49596</p> <p>50580</p> <p>Based on observations, interviews, and facility policy review, the facility failed to ensure shower rooms were locked to ensure residents were prevented from having access to equipment or substances that could result in accidents or injuries. The facility failed to ensure the personal care storeroom, and treatment/oxygen room remained locked to prevent resident access to razors, scissors, and chemicals to reduce the risk for injury. This failed practice had the potential to cause harm to cognitive impaired residents if entry was gained. The facility failed to ensure the resident environment remains as free of accidents hazards as is possible.</p> <p>Findings Include:</p> <p>1. On 12/15/2024 at 10:14 AM, the surveyor observed the shower room door unlocked and not closed. The surveyor noted shampoo, body wash, soap and razors inside.</p> <p>2. On 12/16/2024 at 12:25 PM, the surveyor interviewed Certified Nursing Assistant (CNA) # 3 regarding the shower door open and not locked. CNA #3 confirmed the shower door is supposed to be locked, and stated if a resident gets in the shower room, they can hurt themselves or get locked in.</p> <p>3. On 12/17/2024 at 9:30 AM, the surveyor noted the shower room door on 100 hall was unlocked. The surveyor interviewed the Director of Nursing (DON) regarding shower door unlocked. The DON confirmed the shower door was supposed to be locked and stated that risks included, a resident could fall in shower room or get into unlocked cabinet where supplies are stored.</p> <p>4. On 12/15/24 at 10:25 AM, the surveyor observed an unlocked door titled Treatment and Oxygen on the right of the hallway between 2 nursing stations that revealed an unlocked, open box containing keys to doors in the facility including showers, water heater access, and the laundry room. There were 5 bottles of hydrogen peroxide, 3 bottles of iodine, and 4 bottles of 70% isopropyl alcohol located in the cabinet. A bottle of hydrogen peroxide was resting on the left side of the sink. The neighboring door titled storeroom was ajar and contained tall metal cabinets across from each other with medical supplies including hypodermic needles, and a third door marked Personal care (beauty shop) was unlocked.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>5. On 12/15/24 at 10:29 AM, upon entering the Personal Care room observed various hair appliances with tangled cords hanging from a table and spread out across the floor. The top of the table contained hair creme, conditioner, shampoo and a container of shaving cream that stated, keep out of reach of children. The sink had an open razor resting on the right side of the cold-water valve. To the right of the sink was a brown plastic container with a small lidless green container of edging gel stating, keep out of reach of children, and a lidless bottle of hair conditioner resting on top. To the left of the sink was a small white wire rack containing cleaning spray, chlorine disinfectant spray, glass cleaner, and a neutralizing cleaner stating to keep out of reach of children, instructions on washing the eyes when contact is made, and instructions on calling poison control. The counter to the left of the sink held several open bottles of shampoos, and a container of fluid with combs soaking. In the left-hand corner was a brown top cabinet with black handled scissors, and two pair of clippers resting near the front edge with the cords dangling from the right side to the floor. A green shelf was noted hanging on the wall with lamp base, fan, and a lampshade resting on top nearly reaching the ceiling. On exiting the personal care room, Licensed Practical Nurse (LPN) #2 stated the door did not shut to the storeroom and there were things in there as well as the personal care room, that needed to be seen.</p> <p>6. On 12/16/2024 at 8:45 AM, the Administrator provided a policy titled Medications, Storage of, revealing Resident medications should be locked in a medication room, medication cart, or in a locked cabinet.</p> <p>7. On 12/17/2024 at 8:44 AM, the Director of Nursing (DON) accompanied surveyors down the hallway near the 400-hall nursing station. The DON confirmed that the treatment and oxygen, storeroom and personal care doors should be locked to keep residents out. The DON was able to open the unlocked treatment and oxygen room door and revealed that the open key box should be locked to prevent unauthorized access, and noted hydrogen peroxide was at the sink, and the cabinet held alcohol, iodine, and peroxide that she would not want residents to have access too because they could ingest it. The DON confirmed that the door was not staying shut and was not locked to the storeroom, and she would not want residents to have access because they could harm themselves with the supplies that are stored there. Syringes, unopened needles, tube feeding, new sharps container, and boxes of supplies were observed in the storeroom. The DON accompanied surveyors into the personal care room and confirmed that residents should not have access to razors, scissors, cords should not rest in the floor that could be tripped on, the lampshade should not rest against the ceiling, and the cleaning chemicals were at risk of residents ingesting them when the door is left unlocked. The surveyor requested policies.</p> <p>8. On 12/17/2024 at 9:20 AM, the DON revealed that the facility did not have any policies that address doors not being locked, or razors. The DON was checking to see if any policy addressed chemicals not being secured from residents.</p> <p>9. On 12/17/24 at 11:36 AM, the DON provided a policy titled Beautician / Barber Services revealing chemicals are to be stored to prevent accidental ingestion or misuse.</p> <p>10. On 12/17/24 at 4:10 PM, during an interview, the DON revealed the facility did not have any other policy addressing cleaning supply storage.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>11. On 12/15/24 at 10:28 AM, a medication cart (med-cart) was observed to be unlocked located just outside the dining room, in the hallway across from the nurse's station for hall 300/400. LPN #2 was behind the nurse's station gathering the resident's smoking items. LPN #2 left the nurse's station and walked up the hallway into an office adjacent to the 100/200 hall nurse's station. The Med-cart was not in her line of site due to her turning and walking away from the nurse's station and her going into an office. Affixed to the left side of the cart was a red sharp's container with the lid of the container missing the safety flap, exposing the used/contaminated needles, syringes, lancets, and other used winged type blood draw devices and tubing.</p> <p>b. On 12/15/24 at 10:30 AM, LPN #2 came back to the nurse's station and went outside with the residents for their smoke break, without locking/securing the Med-cart.</p> <p>c. On 12/15/24 at 10:36 AM, LPN #2 came back inside the building and walked behind the nurse's station. Surveyor asked LPN #2 to come to the medication cart. LPN #2 said she saw the Med-cart unlocked at 10:30 AM. LPN #2 identified the following items inside the drawers of the unlocked/unsecured Med-cart:</p> <ol style="list-style-type: none"> <li>1. Numerous Hypodermic needles.</li> <li>2. Numerous Individual packages of antiseptic wipes</li> <li>3. Numerous Individual packages of bleach wipes.</li> <li>4. Numerous Insulin Syringes.</li> </ol> <p>d. On 12/15/24, at 11:00 a.m., LPN #2 visually looked inside red Sharp's container affixed to the Med-cart on the left side. LPN #2 said I can see used needles, used lancets, used winged type blood draw needles with tubing and a razor. LPN #2 said anybody could stick their hand in there and get stuck with one of the items and be exposed to any blood born pathogen on the item. LPN #2 said she did not know what the reddish-brown substance smear on the top of the container was or the dried reddish-brown substance running down the outside of the container was.</p> <p>e. On 12/15/24 at 11:38 AM, the Assistant Director of Nursing (ADON) identified the following items inside the drawers of the med-cart:</p> <ol style="list-style-type: none"> <li>1. Numerous hypodermic needles.</li> <li>2. Numerous Individual packages of antiseptic wipes.</li> <li>3. Numerous Individual bleach wipes.</li> <li>4. A pair of nail clippers were in the top drawer.</li> <li>5. Numerous Insulin Syringes.</li> <li>6. Numerous safety syringes.</li> </ol> <p>(continued on next page)</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>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.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 49596</p> <p>Based on observations, interviews, and facility policy review, the facility failed to ensure all drugs and biologicals were stored in a locked compartment and permit only authorized personnel to have access for one of one medication cart.</p> <p>The findings are:</p> <ol style="list-style-type: none"> <li>On [DATE] at 10:28 AM, a medication cart (med-cart) was observed to be unlocked, located just outside the dining room, in the hallway across from the nurse's station for hall ,d+[DATE]. Licensed Practical Nurse (LPN) #2 was behind the nurse's station gathering the resident's smoking items. LPN #2 left the nurse's station and walked up the hallway into an office adjacent to the ,d+[DATE] hall nurse's station. The medication cart was not in her line of site due to her turning and walking away from the nurse's station and her going into an office.</li> <li>On [DATE] at 10:29 AM, the surveyor opened the top drawer of the medication cart and observed medications in the drawer.</li> <li>On [DATE] at 10:30 AM, LPN #2 came back to the nurse's station and went outside with the residents for their smoke break, without locking/securing the med-cart.</li> <li>At 10:36 AM, LPN #2 came back inside the building and walked behind the nurse's station. The surveyor asked LPN #2 to come to the medication cart. LPN #2 said she had noticed the cart was unlocked at 10:30 AM, when she picked up the resident's smoking box. The surveyor asked LPN #2 to identify the medications in the cart and identify the number of pills or tablets in each container.</li> <li>On [DATE], at 10:43 AM, LPN #2 identified the following items and counts:             <ol style="list-style-type: none"> <li>Aspirin 325 microgram (mcg), expiration date of Apr/2025 - 91 pills. With WARNING: if nausea and vomiting occur, consult a doctor. Allergy alert: Aspirin may cause a severe allergic reaction, which may include facial swelling, shock hives, asthma (wheezing). Stomach Bleeding WARNING: This product contains a non-steroidal anti-inflammatory drug (NSAID), which may cause severe stomach bleeding. The chance is higher if you are age 60 or older, if you take other drugs containing prescription or non-prescription NSAIDs (aspirin, ibuprofen, naproxen, or others) have 3 or more alcoholic drinks every day while using this product; take more or for a longer time than directed.</li> <li>Vitamin D3, 125 mcg microgram (5000 International Unit [IU]), expiration date ,d+[DATE], - 50 tablets. Directions to consult your healthcare provider prior to taking high dose vitamin D supplements. Adults take one (1) table with any meal or as directed by a healthcare provider. Do not exceed recommended dosage. WARNING: consult a healthcare provide if taking any medication, have a medical condition (especially hypercalcemia, kidney disease or hypercalcemia, kidney disease or hyperparathyroidism) or are planning a medical procedure. Do not take with other supplements that contain vitamin D, such as multivitamins. Keep out of reach of children. Do not use if product appears to be tampered with or seal is broken.</li> </ol> </li> </ol> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  045378	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  12/18/2024
NAME OF PROVIDER OR SUPPLIER  Woodland Hills Healthcare and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE  1320 West Braden Street Jacksonville, AR 72076	
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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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>c. Vitamin D3 1250 mcg (50,000 IU), 5 tablets. Directions: adults take one (1) tablet weekly with any meal or as directed by a healthcare provider. Not intended for daily use. Warning: Consult a healthcare provider prior to use if on medications, have a medical condition or planning a medical procedure. Not intended for individuals with liver, kidney or bone disease, calcium disorder or malignancies, unless under the direct supervision of a physician.</p> <p>d. Thiamin Vitamin B-1, 100 milligrams (mg), expiration date ,d+[DATE], - 22 tablets. Instructions to ask your health professional before use if taking other medications.</p> <p>e. Vitamin E 90 mg (200 IU) expiration date ,d+[DATE]; 95 soft gels. WARNING: consult your doctor before use. Keep out of reach of children. Do not use if seal under cap is broken or missing.</p> <p>f. Quercetin 500 mg, expiration date ,d+[DATE], 60 capsules. WARNING: Consult your doctor before use if you have any medical condition. Keep out of reach of children. Do not use if seal under cap is broken or missing.</p> <p>g. Non-steroidal anti-inflammatory Tablets 200 mg, expiration date ,d+[DATE], 13 tablets. WARNINGS: Allergy alert: Non-steroidal anti-inflammatory may cause severe allergic reaction. Symptoms may include hives, facial swelling, asthma (wheezing), shock, skin reddening, rash, blisters. If allergy occurs seek medical help right away. STOMACH BLEEDING WARNING: contains an NSAID, which may cause severe stomach bleeding .if taking other drugs for blood thinning (anticoagulant) or steroid drug. HEART ATTACH AND STROKE WARNING: NSAIDs, except aspirin, increase the risk of heart attack, heart failure, and stroke. These can be fatal.</p> <p>h. Stool Softener docusate sodium 100 mg stool softener laxative - 55 soft gels, DRUG FACTS: stop use and ask a doctor if you have rectal bleeding or fail to have a bowel movement after use of a laxative.</p> <p>i. Allergy Relief Loratadine 10 mg Tablets Antihistamine, 24 hour non-drowsy - expiration date ,d+[DATE]: 4 tablets. WARNING: Do not use if have ever had an allergic reaction to this product or any of its ingredients.</p> <p>j. Vitamin B-12, 500 mcg, expiration date ,d+[DATE], -7 tablets, take one tablet daily.</p> <p>k. Ferrous Sulfate, 325 mcg, expiration date ,d+[DATE], 19 tablets, WARNING: Accidental overdose of iron containing products is a leading cause of fatal poisoning in children under 6. Keep this product out of reach of children. In case of accidental overdose, call a doctor or poison control center immediately. DRUG INTERACTION PRECAUTION: Since oral iron products interfere with absorption of oral tetracycline antibiotics, these products should not be taken within 2 hours of each other.</p> <p>l. One-Daily Multi-Vitamin with Minerals expiration date ,d+[DATE], -69 tablets. WARNING: Accidental overdose of iron containing products is a leading cause of fatal poisoning in children under 6. Keep this product out of reach of children. In case of accidental overdose, call a doctor or Poison Control Center immediately.</p> <p>(continued on next page)</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>m. Vitamin D3 25 mcg (1000IU), expiration date ,d+[DATE], - 58 ,d+[DATE] tablets, Keep out of reach of children.</p> <p>n. Cetirizine HCl Tablets, USP 10 mg, Antihistamine, expiration date ,d+[DATE], - 88 tablets, WARNINGS: Do not use if you have an allergic reaction to this product. Ask your doctor before using if you have liver or kidney disease, using sedatives or tranquilizers.</p> <p>o. Antiemetic 12.5 mg Antiemetic, expiration date ,d+[DATE], 12.5 mg - 98 tablets. WARNINGS: Do not use this product, unless directed by a physician if you have glaucoma, a breathing problem such as emphysema or chronic bronchitis, trouble urinating due to an enlarged prostate gland.</p> <p>p. Fish Oil 1000 mg Omega-3 300 mg, 4 soft gels, WARNING: Consult a healthcare provider prior to use if . taking medications, including blood thinners, have a medical condition or are planning a medical procedure. Keep out of reach of children.</p> <p>q. Stool Softener docusate sodium 100 mg stool softener laxative, expiration date ,d+[DATE] - 12 soft gels, DRUG FACTS: do not exceed recommended dose.</p> <p>r. Vitamin D3 50 mcg (2000 IU), expiration date ,d+[DATE], 100 soft gels. Keep out of reach of children,</p> <p>s. Laxative .5 mg, stimulant laxative enteric coated tablets, expiration date ,d+[DATE], 71 tablets, WARNINGS: Do not use if you cannot swallow without chewing. Keep out of reach of children. In case of overdose, get medical help or contact a Poison Control Center right away.</p> <p>t. Vitamin B-12 1000 mcg; 82 ,d+[DATE] tablets total, 23 were pink round tablets, 59 ,d+[DATE] were pink oblong tablets, 2 of the tablets were breaking down in bottle,</p> <p>u. Chewable Gas Relief Tablets Simethicone 80 mg, expiration date ,d+[DATE] - 89 tablets,</p> <p>v. Folic Acid 1000 mcg, expiration date ,d+[DATE], 76 tablets, WARNING: High potency Folic Acid may mask certain Vitamin B-12 deficiency symptoms. Before taking high potency of Folic Acid consult your physician.</p> <p>w. Zinc 50 mg, expiration date ,d+[DATE], 78 tablets, Keep out of reach of children.</p> <p>x. Tube of Clotrimazole &amp; Betamethasone Dipropionate Cream - Resident label attached Resident #37, LPN #2 said this medication has been discontinued. For Topical use only. Expiration date ,d+[DATE].</p> <p>y. A short acting bronchodilator inhaler 3mg/5ml, 85 inhalers with no name.</p> <p>z. Anti-fungal Powder with Miconazole Nitrate 2%, WARNING: For external use only. - 2 bottles.</p> <p>aa. Vitamin B-12 500 mcg; - bottle shows 100 tablets came in the bottle but the actual count is 131 tablets. Expiration date ,d+[DATE],</p> <p>bb. Calcium 600+D5 mcg, expiration date ,d+[DATE], 54 tablets,</p> <p>(continued on next page)</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>cc. Aspirin 325 microgram (mg), expiration date of ,d+[DATE] - approx. ,d+[DATE] bottle. With a WARNING: if nausea and vomiting occur, consult a doctor. Allergy alert: Aspirin may cause a severe allergic reaction, which may include facial swelling, shock hives, asthma (wheezing). Stomach Bleeding WARNING: This product contains a non-steroidal anti-inflammatory drug (NSAID), which may cause severe stomach bleeding. The chance is higher if you are age 60 or older, if you take other drugs containing prescription or non-prescription NSAIDs (aspirin, Non-steroidal anti-inflammatory or others) have 3 or more alcoholic drinks every day while using this product; take more or for a longer time than directed.</p> <p>6. On [DATE] at 11:38 AM, the Director of Nursing (DON) asked if the Assistant Director of Nursing (ADON) could count the remainder of items in the cart. LPN #2 stopped identifying medications and the ADON identified the remainder of the medication and other items in the med-cart:</p> <p>a. Acetaminophen 500 mg, expiration date ,d+[DATE], 99 tablets, WARNINGS: Liver warning - Severe liver damage may occur if you take more than 8 tablets in a 24-hour period. Allergy alert: may cause severe skin reaction.</p> <p>b. Vitamin D3 50 mcg (2000 IU), expiration date ,d+[DATE], 97 soft gels. Keep out of reach of children.</p> <p>c. Fish Oil 500 mg, expiration date ,d+[DATE], 117 soft gels, No lid. The bottle of fish oil was sitting in the med-cart drawer without a lid. 12 soft gels and the lid were lying in the bottom of the drawer.</p> <p>d. Antihistamine Injection 25 MG/ML with a resident name - Resident #8, - 2 vials of 1 ml each. Expiration date of [DATE].</p> <p>e. Cinnamon 1000 mg, 179 capsules, expiration date ,d+[DATE], WARNING: If you take a prescription medication or have any medical condition, consult a physician before using this product.</p> <p>f. A short acting bronchodilator unit dose vials .5 mg &amp; 3 mg*/3 ml. identified as Resident #8 - 5 vials and a discharged resident - 20 vials.</p> <p>g. Mucus Relief 600 mg extended-release bi-layer tablets; 30 tablets, WARNINGS: Ask a doctor before use if you have persistent or chronic cough such as occurs with smoking, asthma, chronic bronchitis, or emphysema, cough accompanied by too much phlegm, in case of an overdose, get medical help or contact a Poison Control Center right away.</p> <p>h. A short acting bronchodilator nebulizer liquid medication, 25 vials for a discharged resident.</p> <p>i. Mucus Relief 400 mg, expiration date ,d+[DATE], 80 tablets. WARNINGS: Ask doctor before use if you have persistent or chronic cough, asthma, chronic bronchitis, or emphysema. In case of overdose get medical help or contact Poison Control Center right away. A second bottle with 87 tablets, expiration date , d+[DATE].</p> <p>j. Gas Relief - Simethicone 80 mg, expiration date ,d+[DATE], WARNINGS: In case of overdose, get medical help or contact a Poison Control Center right away.</p> <p>(continued on next page)</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>k. Antihistamine HCl 50 mg, expiration date ,d+[DATE], 97 capsules, WARNINGS: Ask doctor before use if you have a breathing problem such as emphysema or chronic bronchitis, glaucoma, trouble urinating due to an enlarged prostate gland.</p> <p>l. Acetaminophen 500 mg tablets, ,d+[DATE], 100 tablets; WARNING Liver warning. Severe liver damage may occur if you take more than 4000 mg of acetaminophen in 24 hrs. Contains allergy alerts.</p> <p>m. Heartburn Relief, Famotidine tablets, 10 mg, 34 pills, WARNING: Allergy alert: Do not use if you are allergic to famotidine or other acid reducers. Expiration date ,d+[DATE].</p> <p>n. Antihistamine Injection 25 mg/ml, expiration date [DATE], 1 vial. A second vial belonging to Resident #38.</p> <p>o. Nicotine Transdermal System Patch, 14 mg. note: If swallowed, get medical help, or contact a Poison Control Center.</p> <p>p. Triple antibiotic ointment .1 oz. WARNING: For external use only, ADON confirmed approximately , d+[DATE] of the tube was remaining in tube.</p> <p>q. Regular strength antacid &amp; Anti-gas liquid. ADON confirmed it is ,d+[DATE] bottle of a 12 oz bottle.  WARNING: Ask a doctor before us if you have kidney disease or a magnesium-restricted diet.</p> <p>r. An antibiotic Injection 750 mg 100ML/HR, Quantity 600 of 600, Unopened, expired [DATE], belonging to a resident - 1 large bag flush saline 11 syringes, Bag of IV Primary set/sigma set up, 4 kits.</p> <p>s. There were numerous unidentified loose pills in the bottom of the drawers of the Med-cart. There was a total of 73 whole pills/tablets and 22 half pills/tablets scattered loose in the Med-cart. ADON said she would need to send these to the Pharmacy for identification.</p> <p>7. On [DATE] at 10:36 AM, LPN #2 stated the facility did not use this cart anymore because they had moved all the resident's medications to the other halls where the residents from 400 hall moved. LPN #2 could not tell the surveyor who unlocked the cart or how long it had been unlocked but she had noticed it unlocked when she was gathering the resident's smoking items. LPN #2 said she was concerned with the residents having access to these medications because some, like the aspirin, could cause internal bleeding. LPN #2 stated if a resident got into these and overdosed it would be bad or if they fell the bleeding could be significant or if a resident got something they were allergic to it would be bad.</p> <p>8. On [DATE] at 10:38 AM, RN #5 stated she had not been in the cart today and did not know it was unlocked because they never use that cart.</p> <p>(continued on next page)</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>9. On [DATE] at 11:38 AM, the Assistant Director of Nursing (ADON) said she did not know how long this cart had not been in use, but it had not been used since she started here, and she had only been here a couple weeks. The ADON said the cart should be locked at all times due to the medications in the cart, because if a resident got in the cart and took some of these medications, or was allergic to them, it would be bad. The ADON said if they took too much acetaminophen it could be toxic to their liver, and we would send them to hospital emergency room . The ADON said if a resident got into the aspirin, it could cause significant bleeding.</p> <p>10. On [DATE] at 12:10 PM, the Director of Nursing (DON) said if a resident had gotten into the cart and took the aspirin the resident could sustain a brain bleed, the acetaminophen could cause liver failure, the stool softener could cause excessive diarrhea, the vitamins could cause a number of different issues, the meclizine could be deadly and too much of anything could cause major injuries. The DON said she did not know who all had keys to the cart, but she did not have a key to this cart.</p> <p>11. On [DATE] at 3:00 PM, the DON said she did not know how long it had been left unlocked. The DON said RN #6 reported to her on [DATE], the cart was locked.</p> <p>12. On [DATE] at 3:00 PM, RN #6 said she had not gone to the cart today and she did not work yesterday. RN #6 said the last day she worked was the 8th, and the 6th, before that and that day she noticed it locked.</p> <p>13. On [DATE] at 3:10 PM, the Administrator said the cart had last been accessed when they moved the residents off 400 hall, to the other two halls, and all the resident's medications had been moved. The Administrator said that move took place back in June and July. The Administrator said Pharmacy Services checks things like the med-carts being secured when they come but they would not have been checking that cart since June or July because they were not using that cart. The Administrator said the only person he knew to have a key was the DON but that some other nurses must have a key to the cart. The Administrator said his concern with the cart being unlocked was a fear of someone accessing the cart that should not and accessing the medications because a myriad of things could happen; like aspirin could cause an internal bleed out.</p> <p>14. On [DATE] at 8:45 AM, the Administrator provided a copy of the Medication Storage Policy. The guidelines items:</p> <p>I. All medications for residents must be stored at or near the nurse's station in a locked cabinet, a locked medicine room, or one or more locked mobile medication carts.</p> <p>II. No discontinued, outdated, or deteriorated drugs or biologicals may be retained for use. All such drugs must be returned to the issuing Pharmacy or destroyed in accordance with established guidelines.</p> <p>III. Drugs must be stored in an orderly manner in cabinets, drawers, or carts.</p> <p>IV. An unattended medication cart must remain locked, at all times. In the event the nurse is distracted from the task of passing medications by some unforeseen occurrence, the cart must be locked before leaving it. Or secured in a locked medication room.</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 03508</p> <p>Based on observation and interview, the facility failed to ensure kitchen vents were cleaned to provide a sanitary environment for food preparation; that floors, dish washer and kitchen walls, door and frames were free of rotten wood, chipped floor tiles, debris, dirt, grease, rust, stains, wall tiles were replaced; food items stored in the refrigerator were covered or sealed; expired food items were promptly removed from stock; ice machine and ice scoop holder were maintained in clean and sanitary condition; dietary staff washed their hands before handling clean equipment or food items and hot food items were maintained at or above 135 degrees Fahrenheit on the steam table while awaiting service for 1 of 2 meals observed.</p> <p>The Findings are:</p> <p>1. On [DATE] at 10:17 AM, the following observations were made in the walk-in refrigerator:</p> <p>a. An opened box of sausage on a shelf. The box was not covered or sealed.</p> <p>b. An opened box of bacon. The box was not covered or sealed.</p> <p>c. Unopened 21-pound box of white bread dated [DATE] was on a cart. The manufacturer specification on the box indicated to avoid refrigeration, as it tends to stale the product</p> <p>2. On [DATE] at 10:31 AM, inside the back wall of the ice machine and the ice machine panel in the kitchen had buildup of wet black residue on them. The surveyor asked Dietary [NAME] (DC) #1 if she could wipe the area where wet black residue was observed. She did so, accumulation of black residue easily transferred to the white rag. The surveyor asked Dietary [NAME] (DC) #1 if she could describe what she saw on the back wall of the ice machine, where ice cubes were resting and the panel, where ice touches before dropping into the ice, collect. She stated it was wet, black residue. DC #1 was interviewed and was asked how often the ice machine was cleaned and who used the ice from the ice machine. She stated it was cleaned once a week. The kitchen staff used it to fill beverages served to the residents at mealtimes. The Certified Nursing Assistants (CNA) used it to fill the water pitchers in the residents' rooms.</p> <p>3. On [DATE] at 10:34 AM, the scoop holder attached to the body of the ice machine had wet black residue at the bottom of it and the ice scoop was resting directly on it. DC #1 was interviewed and was asked if she could wipe the wet black residue at the bottom of the scoop holder and if she could describe what she saw at the bottom of the scoop holder, how often does she clean the scoop holder. She stated it had been cleaned daily. DC #1 took it to washing machine. When the wash cycle finished, DA #2 removed the scoop holder, and the stains were gone.</p> <p>4. On [DATE] at 10:58 AM, the following observations were made in the kitchen:</p> <p>a. There were several gaps observed throughout the kitchen floor. The areas that had gaps had multiple stains on them.</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>b. The wall by the Janitor's closet was chipped, exposing the concrete.</p> <p>c. The ceiling air vent, above the ice machine and beverages machine, had accumulation of greasy dirt on it.</p> <p>d. The wall below the ice machine and behind them had buildup of greasy dirt on them.</p> <p>e. The Fluorescent light covers, close to the door leading to the dining room had dirty lint on it.</p> <p>f. Air vent around the Janitor closet and wall above the janitor's closet had black and grayish spots on them.</p> <p>g. Both sides of the oven were covered in rust. A knob was missing at the middle of the stove. One knob was loose, and the area exposed had buildup of greasy white film on it. The floor drainage by the oven had accumulation of dirt in it. Dietary Supervisor stated it doesn't work.</p> <p>h. The walls leading to the walk-in refrigerator were chipped, exposing the cement.</p> <p>i. The edges of the deep fryer had grease build up hanging down from them.</p> <p>j. The walls by the 3-compartment sink had peeling paint exposing the cement.</p> <p>k. The air vent and ceiling tiles around the vent hood had grease dirt, sage color, and rust build up on it.</p> <p>l. The ceiling tiles, above the counter close to the steam table, had water damage in 4 different areas.</p> <p>m. The wall above the hand washing sink had peeling paint, exposing the cement.</p> <p>n. The pipe attached behind the oven, and deep fryer had black and brown greasy stains on it</p> <p>5. On 12XXX,d+[DATE] at 11:07 AM, the following observations were made in the storage room.</p> <p>a. Thirty -two cartons of nectar thickened cranberry cocktail on a shelf in the storage room had expiration date of [DATE].</p> <p>b. A container of ground nutmeg on the spice rack had best use by [DATE].</p> <p>6. On [DATE] at 11:42 AM, the following observations were made in the dish washing machine:</p> <p>a. One vent in the dish washing machine had buildup of greasy stains in them</p> <p>b. The ceiling panels in the dish washing machine had rust on them.</p> <p>c. The wall of the dish machine had two of two bottom door frames in the dish washing machine leading to the dining room were missing, exposing the metal.</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>d. The wall in the dish machine room had sage color.</p> <p>e. The ceiling vent in the dish washing machine had buildup of greasy dirt on it.</p> <p>f. The door frames leading to the dining room from the dish washing machine had rust on them.</p> <p>g. The wall on the dirty side of the dish washing machine was chipped, exposing the cement.</p> <p>7. On [DATE] at 11:50 AM, Dietary Aide (DA) #2 picked up a pitcher turned on the sink faucet and poured beverages in each glass to be served to the residents for supper. Dietary Aid was interviewed and was asked what she should have done after touching dirty and before handling clean equipment; she stated she should have washed her hands.</p> <p>8. On [DATE] at 12:12 PM, Food temperatures on the steam table when checked and read by DC #1 were:</p> <p>a. Pureed cut green beans, 120 degrees Fahrenheit.</p> <p>b. gravy, 120 degrees Fahrenheit.</p> <p>c. Pureed bread with milk, 100 degrees Fahrenheit.</p> <p>d. Fortified mashed potatoes, 121 degrees Fahrenheit.</p> <p>e. Brussel sprouts, 125 degrees Fahrenheit.</p> <p>The above food items were not reheated before being served to the residents for supper meal.</p> <p>9. A review of facility policy titled, Hand washing not dated and provided by the Dietary Supervisor indicated hands should be washed when entering the kitchen at the start of a shift and after engaging in other activities contaminating the hands.</p>

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NAME OF PROVIDER OR SUPPLIER  Woodland Hills Healthcare and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE  1320 West Braden Street Jacksonville, AR 72076	
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<p>F 0838</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations and emergencies.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 50580</p> <p>Surveyor: [NAME], [NAME]</p> <p>Based on document review and interviews, the facility failed to ensure the necessary care, and resources were allocated to meet the needs of the residents. The facility failed to ensure the amount of hours worked by the Infection Preventionist, based on the facility and resident population, was addressed in the Facility Assessment in order to meet resident needs. This deficient practice had the potential to affect all residents of the facility. The total census was 52 residents.</p> <p>1. On 12/17/2024 at 3:30 PM, this surveyor interviewed the Administrator regarding low weekend staffing. The Administrator was aware of low weekend staffing for Certified Nursing Assistants for the weekend for the 4th quarter. Several call-ins for the weekend with no replacement found. The Administrator had hired 3 weekend only staff to rectify the problem.</p> <p>2. On 12/18/2024 at 8:24 AM, this surveyor noted the Facility Assessment Tool Staffing Plan indicated the Staffing plan for Direct care staff revealed, 1:x6 Direct Care ratio Days, 1:x9 Direct Care ratio Evenings, 1:x14 Direct Care ratio Nights.</p> <p>3. On 12/17/24 at 1:20 PM, the Administer was asked about the availability of the Infection Preventionist (IP) for interview. He stated, she is only part time, and I'm not sure when I can get her in here, but I could try to get her on the phone. Later that day the Administrator stated, I can get her here on Wednesday (12/18/24) by 11:00 AM.</p> <p>4. Upon review of the attendance/time clock data for the IP, the hours worked in the last 3 months varied, and the average number of hours worked per week were approximately 8.25. Typically ranging from 5-10 hours per week.</p> <p>5. Upon review of the State Operations Manual regarding the specifications/regulation regarding an Infection Preventionist ' s working part time, the regulation stated the following: IP hours of work per week can vary based on the facility and its resident population. Therefore, the amount of time required to fulfill the role must be at least part-time and should be determined by the facility assessment, conducted according to S483.70(e).</p> <p>6. Upon review of the Facility Assessment, the Infection Preventionist was not included in the staff, and it does not address the minimum amount of working hours needed for the IP specific to the facility ' s current census or resident needs.</p> <p>7. On 12/18/24 at 11:23 AM, the Infection Preventionist was interviewed regarding her position and duties. When asked when she worked at the facility, the IP stated, I work part time here, typically on the weekends. She confirmed her average hours she worked for [Facility name] were under 10 hours a week, and that her main focus was the antibiotic stewardship and tracking and trending.</p> <p>(continued on next page)</p>		

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F 0838  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Many	8. On 12/18/24 at 11:45 AM, the administrator was interviewed regarding the IP and the Facility Assessment. The Administrator confirmed the Facility Assessment did not include the IP and did not discuss the minimum working hours the facility would require for the IP to work related to their current census and specific needs.		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p>50923</p> <p>Based on observations, record review, and interviews, the facility failed to provide a safe and sanitary environment for residents. In addition, the facility failed to clean and sanitize equipment such as shower beds/chairs, electric clippers used to cut facial hair, wheelchairs, walkers, and lift equipment. These findings have the potential to affect all 52 residents.</p> <p>The findings are:</p> <p>On 12/15/24 at approximately 10:15 AM, observed a medication cart labeled 400 hall nurse , with a sharps container attached to the side with a reddish-brown substance dried on the outside.</p> <p>On 12/15/24 at 10:30 AM, observed the beauty shop was unlocked and observed the trash can was overflowing with a pile of plastic and hair. What appeared to be a long dark hair extension/weave resting on top of the trash can. There was a large pile of different colored hair laying in the sink approximately 2 inches deep along with a red paddle brush, yellow comb, and black hairbrush, all with hair in the bristles. There were baskets containing attachments and other hairbrushes/combs, all covered in hair. The countertops were dirty and dusty, and other equipment such as electric trimmers and clippers covered in hair of many different textures and colors. There was no disinfectant solution or disinfectant wipes present used to disinfect supplies or equipment.</p> <p>On 12/15/24 at approximately 12:00 PM, the surveyor observed the 100-hall shower room was unlocked. The room had a foul musty odor, also smelled like urine. The shower floor was covered with a black and brown substance and had a slippery residue without moisture present. The shower heads were laying in the floor. The shower bed and shower chairs present had black and brown marks down the sides of the white plastic frame. The stretchy mesh portion (the area a resident would sit or lay on) showed areas of discoloration of black and brown spots. The countertop and sink had dust, hair, and other unknown substances. There were several used toothbrushes sitting in a cup next to the sink.</p> <p>On 12/15/24 at 11:00, the surveyor observed the resident rooms on 100 hall. The rooms smelled like a bleach type odor, that was strongest in the bathrooms. An unknown substance was in the toilet bowl. The floors appeared to be clean in areas, but several areas had sticky substances within the grout and on the tile. The bathroom floor bullnose area (functional area where the tile floor extends up the wall) was darker with what appeared to be dirt and hair.</p> <p>On 12/15/24 at approximately 12:45 PM, the surveyor observed the supplemental snack room, close to the nurse ' s station, for 100 and 200 halls. When the surveyor stepped inside, the countertops were noted to have a thick layer of dirt and dust present. The sink was not draining and had a slimy residue around the drain with water standing. When the refrigerator was opened, there was a tray of drinks and snacks for the residents on the bottom shelf. Inside the door, several opened drinks were noted including an opened can of lemon lime drink, an opened bottle of muscle milk, an opened bottle of water, and an opened energy drink.</p> <p>On 12/15/24 at 1:20 PM, the surveyor observed the bathrooms on 100 hall. The bathrooms appeared to have dust and hair covering the safety bar, and portions of the countertops. The walls and floor were dirty with hair and dust, and the trash was overflowing with paper towels.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 12/16/24 at 9:26 AM, the surveyor observed the supplemental snack room near the 100 and 200 nurse ' s station. Inside the refrigerator, there was a tray with snacks and drinks for the residents. The refrigerator had several opened drinks in the door including: a clear cup with a red liquid, an opened water bottle, and an unopened energy drink can.</p> <p>On 12/16/24 at 9:45 AM, the Director of Nursing (DON) was interviewed, regarding the refrigerator contents. The DON confirmed the drinks in the refrigerator were employees ' drinks and they used that refrigerator to keep their food and drink items. The surveyor walked with the DON and CNA #4 to the beauty shop to discuss equipment used by the staff to shave residents. CNA #4 stated they used two different clippers located in the beauty shop for longer facial hair to remove or trim. CNA #4 stated, Just last week I used them, a black one and a smaller white one on a resident to trim their beard up. The surveyor pointed to the clippers and asked CNA #4 if these were the ones she had used, and she stated, Yes, the black one and the white one. Upon inspection of both, many different colors and textures of hair were noted on the clippers. When asked about their process of cleaning the clippers before and after using, CNA #4 confirmed they were not cleaning either before or after but said they should have been cleaned.</p> <p>On 12/17/24 at approximately 12:30 PM, the surveyor observed both the 100 hall and the 300 hall lifts were soiled with a deep layer (approximately 0.5 inch) of dust, and other unknown substances. Several large (approximately 12 to 20) dark stains were also noted on the carpet on 100 hall. Several residents ' rooms were noted to have staining along the wall, dust and hair in the corners of the rooms and under the beds.</p> <p>On 12/17/24 at 10:20 AM, the surveyor walked with the Administrator to the shower room on 100 hall. The door was unlocked again, and it appeared the room had been cleaned some since the first observation, but the shower floor continued to have a black substance on the tile and in the grout. The room continued to have a foul odor and was musty. During an interview with the Administrator, at that time regarding housekeeping issues, he confirmed they were working with their housekeeping staff and issues with areas within the facility which required deep cleaning. The Administrator stated steps were being taken to improve the cleanliness of the facility included:</p> <ol style="list-style-type: none"> <li>1. Hiring additional staff to ensure adequate staffing.</li> <li>2. Administration and managers more closely monitor the cleaning process.</li> <li>3. Create a more team-like environment for employees to work together.</li> </ol> <p>On 12/17/24 at 9:20 AM, when asked for an infection control policy that addressed housekeeping, the DON stated there was not a policy they could provide specific to these concerns.</p>		

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<p>F 0919</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Make sure that a working call system is available in each resident's bathroom and bathing area.</p> <p>47916</p> <p>Based on observation, interview, and facility policy review, the facility failed to ensure residents had a functioning call light system that would alarm, light up, and could be reset by staff, or a way to contact staff to ensure needs were met for 2 of 2 sampled (Resident #7, and Resident #30) residents.</p> <p>The findings include:</p> <ol style="list-style-type: none"> <li>1. A review of an in-service training report, dated 11/18/2024, revealed staff were instructed to answer call lights in a timely manner.</li> <li>2. On 12/15/2024 at 2:38 PM, Resident #7 stated the call light is not working. The call light button was pushed and did not light up outside the door for Resident #30, but Resident #7's call light functioned. Certified Nursing Assistant (CNA) #9 pressed Resident #30's call light and the call light was not lighting up above the door, and no alarm was heard. CNA #9 revealed that she would attempt to fix the call light because if she does not try nobody else will do it. CNA #9 confirmed in an emergency or if resident #30 needed something the resident would not be able to use the call light.</li> <li>3. On 12/15/2024 at 11:50 PM, the surveyor observed Resident #30 resting quietly, with call light resting on Resident #30's chest, and Resident #7 was sitting in a recliner with call light in reach. Resident #7 confirmed they do not have a bell or way to reach staff. The call light control panel was hanging down by 2 red, and 2 white wires. The red bulbs on the panel were lit up. The reset button was pushed, and the lights stayed on the panel, and the light did not work outside Resident #7 and Resident #30's door. CNA #10 walked in and stated that she was asked to check on Resident #30 and Resident #7 frequently and make sure they were not playing with the wires hanging from the wall or needed anything. They cannot get to the panel.</li> <li>4. On 12/16/2024 at 9:16 AM, Resident #30 was moved to a room with functioning call lights, and the call light control panel was back in the wall.</li> <li>5. During an interview with the Director of Nursing (DON) on 12/17/24 at 4:00 PM, the DON was asked the process for identifying call lights that do not work. The DON revealed that during the daytime hours staff called the Maintenance Director and told him when something was not working. After hours staff called the DON or mainly the Administrator and they will let the Maintenance Director know call lights are not working so he can fix them. The surveyor asked when maintenance reports were filled out. The DON stated staff call the Administrator for the most part. The DON said that staff called Sunday night and said that Resident #30's call light was out, and she bought a bell for Resident #30 's room, and as soon as the nurse found out, they started monitoring the room and documenting. Resident #30 did not have a bell when she was seen at midnight. The surveyor asked when Resident #30 received the bell. The DON revealed that she did not have a bell at that time but brought them in the next morning. The DON confirmed that there was a concern that Resident #30 might not get their needs meet during the time they did not have a functioning call light. The surveyor requested a call light policy, Resident #30 's monitoring log, and any maintenance reports they might have.</li> </ol> <p>(continued on next page)</p>		

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<p>F 0919</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>6. On 12/17/2024 at 04:19 PM, the Administrator provided a Monitoring Log for Resident #7 and Resident #30 showing that nursing knew the call light did not work at 1245 AM, with one-hour checks, and revealed a bell was given to resident at 7:45 AM. A review of Maintenance Request Log Sheets, dated 09/21/2024-12/02/2024, from the nurse 's station revealed no reports of broken or non-functioning call lights were provided to maintenance.</p> <p>7. On 12/18/2024 at 12:33 PM, a review of a policy titled Call Light, Use Of, revealing bedside call lights should light up above the door/and or sound above the door and light up at the nurse's station. Staff must turn the call light off at the control panel where the alarm originated from. Defective call lights should be reported to the charge nurse and reported to maintenance immediately and logged in the maintenance log. The Call light system should be checked regularly.</p> <p>8. On 12/18/2024 at 3:10 PM, the Maintenance Director was asked the process for reporting broken call lights and things that needed to be repaired and stated, Honestly, most people just tell me in the hallway. The surveyor asked if repairs ever got overlooked because they were not documented. The Maintenance Director confirmed that he had sometimes forgotten what he was told since it is not written down.</p>		