STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045393	A. Building B. Wing	11/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Encore Healthcare and Rehabi of Malvern	1820 West Moline Street Malvern, AR 72104

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 47916 Based on observation, record review, and interview, the facility failed to ensure residents were lowered and raised in a mechanical lift with the rear casters/wheels in the unlocked position to prevent accidents or injury for 1 sampled (Resident #45) resident reviewed for accidents and injuries. Findings include: 1. A review of Medical Diagnoses revealed Resident #45 with diagnoses of Parkinson's, type II diabetes, and Alzheimer's. The Admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 07/23/2024, indicated a Brief Interview for Mental Status (BIMS) score of 03 (0-7 suggest cognitively impaired). Resident #45 required total care for bathing, dressing, and personal care. a. A review of Resident #45's Care Plan, dated 07/31/2024, revealed Resident #45 was dependent on 2 or more helpers doing all the effort for toileting and transfers using a mechanical lift with a green lift pad. b. Review of the mechanical lift instruction manual page 2 indicated not to lock the casters during lifting. c. On 11/18/2024 at 11:28 AM, Certified Nursing Assistant (CNA) #5 and CNA #6 were observed rolling Resident #45 over the bed in a mechanical lift. CNA #5 locked the rear casters/wheels and left the legs in the open position while lowering and raising Resident #45. The CNAs were asked the process for lowering and raising a resident while in the mechanical lift, and CNA #5 stated that they open the legs so that it keeps the lift from turning over, and the wheels are locked to keep the mechanical lift from rolling and moving on them. CNA #5 confirmed the facility provides mechanical lift training. d. During an interview with the Director of Nursing (DON) on 11/20/24 at 09:24 AM, the DON was asked what process staff are expected to use when lifting and lowering residents with a mechanical lift. The DON stated she would have to look and suspected the legs are to be open when raising and lowering residents for stability. After reviewing a copy of the manual guide on page 2, the DON confirmed that the casters/wheels of the mechanical lift are to remain unlocked when raising and lowering a resident but noted the manual did not explain why. (continued on next page)

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

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	e. On 11/20/24 at 10:12 AM, the Director of Nursing (DON) provided documentation of staff competencies that showed CNA #6 had been trained on the lift.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 47916 Based on observation, record review, interview, and facility policy review, it was determined that the facility nursing staff failed to label an anti-anxiety medication stored in the refrigerated narcotic box in the 300-hall medication room with the open and use by date to prevent expired medication from being administered to residents beyond the recommended use by date. The findings include: a. A review of an in-service titled, Narcotic Expiration, dated [DATE], revealed staff are to be mindful of the expiration dates on narcotics by dating bottles when opened, and lorazepam will expire 60 days from the date opened. Review of a policy titled, Medication Storage in the Facility, revised [DATE], revealed to ensure medication potency and purity, certain medications require an expiration date that is shorter than the manufacturers expiration date. The pharmacy will carry a beyond use date that is determined by regulations and the law. Multi dose packaging will have a beyond use date of 60 days. Medications should be dated when the manufacturer ' s seal is broken, and staff should place the date opened on the bottle, and the new date of expiration. b. On [DATE] at 2:51 PM, the Surveyor observed a resident had an unopened bottle of anti-anxiety oral concentrate 2mg/ml (milligram/milliliter), and a second opened bottle of anti-anxiety medication resting in the locked narcotic box in the 300 Hall medication room. The plastic storage bag was dated [DATE] for the open bottle. The Do Not Use Beyond sticker on the bottle and labeled storage bag were not filled out, and the date the medication was opened was not written on the bottle or the plastic bag. Licensed Practical Nurse (LPN) #7 revealed she was not sure when the medication was opened. Narcotic page 15 was started on [DATE], and showed the last dose given was on [DATE]. LPN #7 located the original entry from a retired drug book on page 60, showing the medication was first opened on [DATE]. LPN #7 was unable to confirm how many days anti-anxiety oral concentrate was good from the time opened and would get back to the Surveyor after speaking with the Director of Nursing (DON). c. On [DATE] at 7:45 AM, the Director of Nursing (DON) was asked what process nursing was expected to use to determine when a medication was expired. The DON stated they have spoken with the pharmacist and threw away both bottles of anti-anxiety medication because he told them the medications were past their expected beyond use date including the unopened bottle, and she confirmed the pharmacist told them anti-anxiety oral medication was good for 90 days after opening, but the policy was 60 days. When asked if it was appropriate to administer anti-anxiety medication on [DATE] from a bottle that was opened on [DATE], the DON confirmed that it was not appropriate to administer anti-anxiety medication from a bottle that was opened on [DATE] because it might be less potent and not benefit the resident.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. 03508 Based on observation, record review, and interview, the facility failed to ensure meals were prepared and served according to the planned written menu to ensure that nutritionally balanced meals were provided for the residents for 2 of 2 meals observed. The findings are. 1. On 11/18//2024, the menu for noon meal indicated residents on pureed diets were to receive a #6 scoop (2/3 cup) of pureed chicken and dumpling and a #8 scoop (1/2 cup) of pureed cornbread. On 11/18/24 at 12:48 PM, the following observations were made during the noon meal service. a. Dietary Aide (DA) #1 used a #16 scoop (1/4 cup) to serve a single portion of pureed cornbread to the residents on pureed diets, instead of a #8 scoop (1/2 cup). On 11/19/24 at 8:45 AM, DA #1 when asked during an interview what spoon size she had used when serving pureed cornbread to the residents who required pureed diets. DA #1 stated she used the blue scoop (#16) which was equivalent to 1/4 cup to give a single serving to each resident. When asked if she looked at the menu DA #1 confirmed she did not. The kitchen staff always use the blue scoop to serve pureed cornbread. b. DA #1 used a #8 scoop (1/2 cup) to serve a single portion of pureed chicken and dumpling to the residents on pureed diets, instead of a #6 scoop (2/3 cup). At 12:53 PM, DA #1 when asked during an interview what spoon size she had used when serving chicken and dumpling to the residents who required pureed diets. DA #1 stated she made a mistake, by using a #8 scoop to give a single serving to each resident that she should have use #6 scoop instead. 2. On 11/19/2024, the menu for breakfast meal indicated residents on pureed diets were to receive a #8 scoop (1/2 cup) of pureed French toast. On 11/19/2024 at 8:09 AM, DA #1 served a single portion of pureed French toast with a #16 scoop which was equivalent to 1/4 cup, instead of a #8 scoop (1/2 cup). At 10:40 AM, DA #1 when asked during an interview what scoop size she had used when serving pureed French toast to the residents on pureed diets she stated blue scoop (#16) which was equivalent to 1/4 cup. DA #1 stated she knew now she should be looking at the menu before serving meals.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 03508 Based on observation, interview, record review, and facility policy review, the facility failed to ensure dietary staff thoroughly washed their hands and changed gloves when contaminated and before handling food and clean equipment when contaminated; food items stored in the refrigerator, freezer and dry storage area were covered, sealed or dated; expired food items and spices were promptly removed/discarded on or before the expiration or use by date, and hot food items were maintained at 135 degrees Fahrenheit or above for 2 of 2 meals observed. The findings are: 1. On [DATE] at 8:59 AM, an opened box of sausage was observed on a shelf in the walk-in refrigerator. The box was not covered or sealed. 2. On [DATE] at 9:15 AM, the following observations were made on a shelf in the walk-in freezer. a. An opened box of biscuits. The box was not covered or sealed. b. An opened box of chicken fried steak. The box was not covered or sealed. 3. On [DATE] at 9:19 AM, the following observations were made on a shelf in the storage room. a. One container of ground cloves with an expiration date of [DATE]. b. One container of ground thyme with an expiration date of [DATE]. 4. On [DATE] at 9:41 AM, two of two cartons of jelly were observed on a self in the refrigerator, in the nourishment room leading to 400-hall, with an expiration date of [DATE]. On [DATE] at 9:42 AM, the following cartons of desserts were on a shelf in the refrigerator, in the nourishment room leading to 400-hall, there were no dates when the desserts were received: a. Two cartons of strawberry yogurt. b. Two cartons of blueberry yogurt. c. One carton of banana supreme yogurt. d. One carton of protein peach. e. One bowl of cheesecake yogurt. f. One bowl of pumpkin pie. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	5. On [DATE] at 10:18 AM, Dietary Aide (DA) #1 removed two sticks of butter from the refrigerator and placed them on the counter. Without washing her hands, she picked up glasses by their rims and placed them on the trays to be used in serving beverages to the residents for lunch. 6. On [DATE] at 10:58 AM, Dietary Aide (DA) #2 pushed plate warmer towards the steam table. Without washing his hands, DA #2 picked up plates and placed them on the counter with his fingers inside of them. DA #2 was interviewed and was asked what he should have done after touching dirty objects and before handling clean equipment, DA #2 stated he should have washed his hands. 7. On [DATE] at 11:14 AM, DC #3 walked out of the refrigerator and then pulled his pants, contaminating his hands. Without washing his hands, he picked up a clean blade and attached it to the base of the blender to be used in pureeing food items to be served to the residents for lunch. DC#2 was interviewed and was asked what he should have done after touching dirty objects and before handling clean equipment, DC #2 stated he knew he should have washed his hands before picking up the blade. 8. On [DATE] at 11:53 AM, DC #3 removed a carton of milk from the refrigerator and placed it on the counter, contaminating his hands. Without washing his hands, DC #3 picked up a clean blade and attached it to the base of the blender. He picked up gloves and placed them on his hands, contaminating the gloves in the process. At 11:55 AM, DC #3 used his contaminated gloved to pick up slices of cornbread to place into a blender. When he was asked what he should have done after touching dirty objects and before handling clean equipment, DC #3 stated he should have washed his hands. 9. On [DATE] at 12:28 PM, the temperatures of the tomato soup checked and read by the Dietary [NAME] (DC) #4 after been heated up in the microwave were: a. First bowl of tomato soup was 121 degrees Fahrenheit, and second bowl of tomato soup was 122 degrees Fahrenheit when served. The above soups were not reheated before being served to the residents who requested tomato soup with their lunch meal. DC #4 was interviewed and was asked what she should she have done when food items are not at the required temperature before being served to the residents, she stated she should have reheated it. 10. On [DATE] at 1:00 PM, Dietary [NAME] (DC) #4 was observed removing a bag of shredded lettuce from the refrigerator and placing it on the counter. DC #4 picked up gloves and placed them on her hands, contaminating the gloves in the process. At 1:03 PM, DC #4 unzipped the bag that contained shredded lettuce and used her contaminated gloved hand to remove shredded lettuce from the bag and placed them on the plates to serve to the residents who requested salad with their noon meal. DC #4 was interviewed and was asked what she should have done after touching dirty objects and before handling clean equipment, DC # 4 stated she should have washed her hands. 11. A review of facility policy titled, Hand Washing and Glove Usage in Food Service, initiated 2016, provided by the Dietary Manager on [DATE] indicated, employees should wash their hands before starting work and after touching anything else like dirty equipment and work surfaces.