STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045394	A. Building B. Wing	06/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rector Nursing and Rehab	1023 Highway 119 Rector, AR 72461

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 49689 Based on observation, record review, and interview, the facility failed to ensure all residents who were seated at the same table were fed at the same time to promote resident dignity for 3 (Residents #7, #14, and #27) of 3 sampled residents. The findings are: 1. A review of the Order Summary revealed Resident #7 had diagnoses of Alzheimer disease, and cognitive communication deficit. A review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 05/03/2024 revealed Resident #7 scored a 3 (severe cognitive impairment) on a Brief Interview for Mental Status (BIMS). A review of the Care Plan revealed Resident #7 was able to feed self after set up. 2. A review of the Order Summary revealed Resident #14 had diagnoses of stroke, aphasia, and hemiplegia and hemiparesis affecting the right dominant side. A review of the Quarterly MDS with an ARD of 05/20/2024 revealed Resident #14 scored a 7 (severe cognitive impairment) on a BIMS. A review of the Care Plan revealed Resident #14 required extensive assistance of one person and can hold and eat fingers foods. 3. A review of the Order Summary revealed Resident #27 had diagnoses of dementia, cognitive communication deficit, and dysphagia. A review of the Quarterly MDS with an ARD of 05/23/2024 revealed Resident #27 had a Staff Assessment for Mental Status (SAMS) performed which revealed the resident's cognitive skills for daily decision making were severely impaired. A review of the Care Plan revealed Resident #27 was able to hold finger foods and needed assistance with the rest of meal. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 06/11/2024 at 12:20 PM, the Surveyor observed the residents were seated around the assist table. A staff member was assisting Resident #14 at the end of the table, to the left was Resident #7 and to the right was Resident #27. The Surveyor observed Resident #7 and Resident #27 kept looking over at Resident #14's lunch tray. The Surveyor observed Resident #14 was being assisted with chocolate ice cream and chocolate milk. On 06/11/2024 at 12:25 PM, during an interview, Certified Nursing Assistant (CNA) #1 stated that this is where the residents usually sits at, and now that I think about it, they should be seated at a different table. CNA #1 then stated that if these residents are hungry, they are watching this resident eat and they do not have any. CNA #1 stated that I would feel terrible absolutely terrible. On 06/12/2024 at 11:24 AM, during an interview with the Administrator, she stated that the whole table is to be served on a normal day to day basis. Yesterday, Resident #14 had an appointment and had to be fed early. The Administrator then stated that this could be a dignity issue when eating in front of another resident. A review of the policy Dignity stated, Policy Statement: Each resident shall be cared for in a manner that promotes and enhances his or her sense of well-being, level of satisfaction with life, and feelings of self-worth and self-esteem .

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. 49689 Based on observation, record review and interview, the facility failed to ensure interventions were utilized to prevent worsening of contractures in 1 of 1 sampled resident (Resident #14). The findings are: a. A review of the Order Summary revealed Resident #14 had diagnoses of stroke, aphasia (a language disorder that affects how you communicate), and hemiplegia and hemiparesis (complete paralysis and partial muscle weakness) affecting the right dominant side. b. A review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date of 05/20/2024 revealed Resident #14 scored a 7 (severe cognitive impairment) on the Brief Interview of Mental Status (BIMS). A review of Section GG reveals Resident #14 has limited range of motion impairment on one side for upper and lower extremity. c. A review of Resident #14's Care Plan revealed: Focus: The resident has an ADL [activities of daily living] self-care performance deficit R/T [related to] muscle weakness, abnormal gait, vision and CVA [Cerebral Vascular Accident (stroke)] . Goal: The resident will maintain current level of function in in ADLs through the review date . Intervention: NURSING hand rolls in bilateral hands. d. A review of Resident #14's Care Plan revealed: Focus: Weakness and Right-Hand Contracture, Goal: to muscle weakness, Interventions: resident to have hand splint on while up. e. On 06/10/2024 at 11:30 AM, the Surveyor observed Resident #14 to be up in the dayroom next to the nurse's station. The right hand was contracted into a closed fist with no interventions in place. f. On 06/10/2024 at 1:30 PM, the Surveyor observed Resident #14 to have no interventions in the right hand. The right hand was still closed like a fist. g. On 06/11/2024 at 12:20 PM, the Surveyor observed Resident #14 eating lunch in the dining room. No interventions were in the right hand. The right hand was still closed like a fist. h. On 06/12/2024 at 9:30 AM, the Surveyor observed Resident #14 being pushed to their room, no interventions were in the resident's right hand. The right hand was still closed like a fist. i. On 06/12/2024 at 9:40 AM, during an interview Certified Nursing Assistant #1 (CNA) stated that she is familiar with Resident #14's care, usually I float the building. CNA #1 then stated Resident #14 had interventions, but they are lost and have not been able to find them to use as normal. CNA #1 stated she did not know how long the interventions had been lost. CNA #1 stated they usually use a hand roll, but they could have used wash clothes as well. CNA #1 stated the contracture could worsen, if not cleansed properly and could become red and irritated. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	j. On 06/12/2024 at 11:04 AM, during an interview Certified Occupational Therapist Assistant (COTA) #3 stated the restorative aide left recently, and I was not informed about the missing hand roll. Then stated they had got that at another facility for the resident as it pumps up to slowly expand the contracture, as the resident's contracture was so difficult to start with. k. On 06/12/2024 at 2:05 PM, during an interview Licensed Practical Nurse (LPN) #2 stated the resident was supposed to have a hand roll in place for the contracted hand. LPN #2 then stated without an intervention the contracture will not correct itself, and it will not have the inability to stretch, not allowing staff to perform nail care. Then LPN #2 stated this can cause redness, wounds, and infections if it was not properly cleansed or taken care of. l. A review of the policy Restorative Nursing Services stated, .5. Restorative goals may include but are not limited to supporting and assisting the resident in: a. Adjusting or adapting to changing abilities; b. developing, maintaining, or strengthening his/her physiological and psychological resources .

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NAME OF PROVIDER OR SUPPLIER Rector Nursing and Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE 1023 Highway 119 Rector, AR 72461	

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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** 49981 Based on observation, interview, and policy review, the facility failed to ensure controlled medications were stored in a locked and permanently affixed box in the medication refrigerator. The findings are: 1. On 6/12/2024 at 9:30 AM, during observation of the medication storage room, the Director of Nurses (DON) was showing locked boxes of controlled medications in a mini fridge inside of Medication Storage room [ROOM NUMBER]. There was a larger black box, which had a lock on it and was affixed to a refrigerator shelf. There was a smaller black box, which was also locked, but the DON was able to pick it up off the shelf. The DON said, I don't think I have a key to this one. The DON and the Surveyor stepped outside of the storage room, while the DON went and got the key to unlock the small black box. The DON returned with the key and unlocked the smaller black box. It contained liquid Ativan (Lorazepam). The DON said, I believe that should be affixed to the refrigerator shelf. a. On 06/12/2024 at 3:04 PM, a policy on Medication Labeling and Storage was provided by Administrator. b. The policy stated under Medication Storage, article #7, Controlled substances (listed as Schedule II-V of the Comprehensive Drug Abuse Prevention and Control Act of 1976) and other drugs subject to abuse are separately locked in permanently affixed compartments, except when using single unit package drug distribution systems in which the quantity stored is minimal and missing dose can be readily detected. c. On 06/13/2024 at 9:25 AM, the Surveyor asked the Administrator where controlled medications are to be stored. The Administrator said, In a locked box affixed to something permanent.