STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045401	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/21/2024
NAME OF PROVIDER OR SUPPLIER: White River Healthcare		STREET ADDRESS, CITY, STATE, ZIP CODE: 1569 AR Highway 56, Calico Rock, AR 72519	

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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 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. 50505 Based on record review and record interview, it was determined that the facility failed to notify the resident/representative or Power of Attorney (POA) in writing of the resident's transfer/discharge to the hospital as required for Resident #5 of 1 resident reviewed for the process of notification at time of transfer/discharge. Findings include: A review of a facility policy titled, Transfer or Discharge Notice, revised in December 2016, made no indication of notifying the resident/representative or POA. The policy indicated that a written notice would be sent in the event of an impending transfer or discharge within 30 days. A review of Resident #5 ' s Admission Record, indicated the facility admitted Resident #5 with diagnoses that included congestive heart failure, atrial fibrillation, stage 3 chronic kidney disease and a personal history of urinary tract infections. Review of the annual Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 11/06/2024, revealed Resident #5 had a Brief Interview for Mental Status (BIMS) score of 3 which indicated Resident #5 had severe cognitive impairment. Resident #5 was indicated as always incontinent of bowel and bladder and was receiving antibiotic therapy. The discharge return anticipated MDS, with and ARD of 08/13/2024 was completed. A review of Resident #5 ' s order details dated 08/13/2024, noted to send Resident #5 to the emergency room (ER) for evaluation and treatment. A review of the progress notes revealed on 08/13/2024 that Resident #5 was having labored respirations with use of accessory muscles and periods of apnea. Resident #5 was unresponsive to verbal stimulus. Family wanted Resident #5 sent to the ER. A review of the computerized telephone message on 11/21/2024, revealed that the facility sent the message on 08/14/24 at 3:51 pm. The message sent stated, state regulations require the facility send out a letter to the family, along with notification by phone. (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 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/21/2024 at 10:55 AM, the social service director stated that the way the facility communicates with resident/representatives was with the computerized telephone message system and that the facility does not send anything in writing for the bed hold policy nor the reason why the resident was sent to the hospital. The facility does not have a business office manager currently.

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. 50505 Based on record review and interview, it was determined that the facility failed to notify resident representatives or Power of Attorney (POA) in writing of the bed hold policy upon a resident's transfer to the hospital and/or discharge as required for 1 (Resident #5) of 1 resident reviewed for bed hold notification. Findings include: A review of a facility policy titled, Transfer or Discharge Notice, revised in December 2016 made no indication of notifying the resident/representative or POA. The policy indicated that a written notice would be sent in the event of an impending transfer or discharge within 30 days. A review of Resident #5 ' sAdmission Record, indicated the facility admitted Resident #5 with diagnoses that included congestive heart failure, atrial fibrillation, stage 3 chronic kidney disease, and a personal history of urinary tract infections. The annual Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 11/06/2024, revealed Resident #5 had a Brief Interview for Mental Status (BIMS) score of 3 which indicated Resident #5 had severe cognitive impairment. Resident #5 was indicated as always incontinent of bowel and bladder and was receiving antibiotic therapy. The discharge return anticipated MDS, with and ARD of 08/13/2024 was completed. A review of Resident #5 ' s order details dated 08/13/2024, noted to send Resident #5 to the emergency room (ER) for evaluation and treatment. A review of Resident #5 ' s progress notes revealed on 08/13/2024, indicated that Resident #5 was having labored respirations with use of accessory muscles and periods of apnea. Resident #5 was unresponsive to verbal stimulus. Family wanted Resident #5 sent to the ER. A review of the computerized telephone message on 11/21/2024 revealed that the facility sent the message on 08/14/24 at 3:51 pm. The message sent indicated with each transfer it was required that the facility send a copy of the bed hold policy. During an interview on 11/21/2024 at 10:55 AM, the social director stated that the way the facility communicates with resident/representatives was with the computerized telephone message system and that the facility does not send anything in writing for the bed hold policy nor the reason why the resident was sent to the hospital. The facility does not have a business office manager currently. The social director stated that the notifications were sent by the social department.

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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. 49413 Through observation, record review, and interview, the facility failed to ensure one of one resident sampled (Resident #31) environment remained free of accident hazards as was possible. The findings are: Record review of quarterly Minimum Data Set with an Assessment Reference Date of 09/10/2024, revealed for Section C, Cognitive Patterns, Resident #31 showed a Brief Interview for Mental Status of 15. Record review of Resident # 31 ' s Admission Record showed two Power of Attorneys for Care Conference. Record review of a Care Plan dated 9/10/2024, did not have documentation to support Resident # 31 to self-administer medicine. During an observation on 11/18/2024 at 11:05AM, in Resident # 31 ' s room a bottle of nasal spray was on rolling bedside table, while cough drops and wound cleanser were on the dresser. During an interview on 11/18/2024 at 11:09AM, LPN #1 confirmed wound cleanser should not be in Resident # 31 ' s room. LPN #1 stated she did not know where the nose spray or cough drops came from and should not be in Resident # 31 ' s room either. During an interview on 11/20/24 at 2:21PM, Director of Nursing confirmed the nose spray, cough drops nor wound cleanser should be in Resident # 31 ' s room. Resident # 31 should not be self-administering and the nose spray, cough drops, and wound cleanser should have been brought out if nurses administered. There was a concern the medicine could be used improperly by Resident #31. On 11/21/2024 a review of Self Administration of Medication Policy from Nursing Policy and Procedure Manual for Long-Term Care 2001 MED-PASS, Inc. (Revised February 2010) showed the interdisciplinary team (IDT) is to assess each resident to determine if self-administration is safe and clinically appropriate for the resident. The following was considered for self-administration; is the medication appropriate for self-administration, is resident able to follow directions and tell time to know when to take the medication, does resident understand the proper dosage, side effects and what to report to staff. When self-administration is considered, appropriate documentation is made in the medical record and the care plan. Self-administered medications are stored in a safe and secured area where other residents do not have access.

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	045401	A. Building B. Wing	11/21/2024

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician. 49413 Through investigation and record review the facility failed to employ staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service. The findings are: During an investigation on 11/19/2024 at 7:43AM, the Dietary Manager confirmed classes have not been started for dietary certification. During an investigation on 11/21/2024 at 9:02AM, the Administrator confirmed the Dietary Manager took position on 12/31/2022. Facility was working on Dietary Manager to be enrolled in a program, paperwork had not been finished. Review of an email dated 08/8/2024 at 7:00AM, from Dietary Consultant provided a list of online programs to the Dietary Manager and the Administrator.

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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. 49413 Through observation, interviews, and policy review, the facility failed to ensure that equipment was in a clean, safe, useable condition and food was stored in a safe and sanitary manner. The findings are: During an observation on 11/19/2024 at 6:20AM, 20 small bowls were placed in a pan on the steam table serving side up without a covering. During an observation on 11/19/2024 at 6:32AM, Refrigerator #2 ' s left, and right door seals held a brownish color with dark brown and black spots along the inside seals. During an observation on 11/19/2024 at 6:33AM, Refrigerator #3 ' s left, and right door seals held a brownish color with dark brown and black spots along the inside seals. The seal contained a purplish discoloration of the seal. During an interview on 11/19/2024 at 6:34AM, the Dietary Manager stated the purplish discoloration was from chemicals used to clean the seals of the brownish color with the dark brown and black spots. Cleaning was unable to remove the unknown substance. The seals look dirty, like there is mold on the seals. The concern is cross contamination from not being able to clean spots off the seals. During an observation on11/19/2024 at 6:35 AM, the stand-up deep freezer had two 4 fluid ounce strawberry flavored ice creams squeezable to the touch; 72 four fluid ounce vanilla fortified shakes, 26 four fluid ounce strawberry fortified shakes; 29 four fluid ounce chocolate fortified shakes had thawed. 63 four fluid ounce chocolate ice cream cups had become pliable. The left and right-side doors of the stand-up deep freezer were wobbly, with condensation water droplets formed on the top portion of the stand-up deep freezer outside center which began to flow down the front surface. Dietary Manager confirmed the ice cream needed to be firm not soft, and the fortified shakes needed to be handed out, not re-frozen. During an observation on 11/19/2024 at 6:44AM, the industrial can opener blade contained a crusty yellowish orange and white unknown substance adhered to the blade. During an observation on 11/19/2024 at 6:28 AM, the standup refrigerator #2 had an unknown black substance on the seal going around the right center door. Dietary Manager stated the seal looks dirty like there is mold on it and there is concern of cross-contamination. During an observation on 11/19/2024 at 6:57AM, dry goods storage room chest freezer #3 seal on the right front corner was peeled back with a hole. The Dietary Manager stated facility was supposed to be replacing the deep freezer. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an observation on 11/19/2024 at 6:59 AM, dry storage room stand up freezer #2 contained two rust lines on the bottom shelf that go from the back freezer wall to the front opening. On the bottom, left-hand corner of the freezer, a switch for the light had holes between the plate and the bottom freezer wall. The freezer's bottom right-hand corner was missing approximately 2 .5-inch plastic that left the insulation exposed. Dietary manager confirmed the rust on the lower shelf could cause cross contamination. The Dietary Manager stated there was not a concern of the exposed insulation or hole by the light switch. During an observation on 11/19/2024 at 7:22AM, the Dietary [NAME] used food tongs to pick up toast wrapped in aluminum foil, then pick up bacon with the same food tongs. Dietary Manager stated the tongs used for the toast should not be used to pick up the bacon. During an interview on 11/19/2024 at 7:24AM, the Dietary Manager confirmed the 20 small bowls on the steam table should be flipped over or have the serving side covered to keep from cross contamination. During an observation on 11/19/2024 at 7:25AM, two deep fryer baskets had a black unknown substance built up on the wire grating throughout both fryer baskets. Wire grating had become loose from the top left side of both deep fryer baskets, this left wire grating end exposed and unsecured. The tall metal wall of the grease catch area, at the back of the deep fryer, showed a built up sticky grimy, black unknown substance. The open compartment at the back of the deep fryer contained brown unknown substance particles suspended within a yellowish grimy build up on the inside back wall, back edges and the front left and right corners. Dietary Manager confirmed there was a concern of wire pieces falling into the food being cooked for the resident's consumption. Dietary Manager stated there was an uncertainty if anything could go back there to clean the area. Dietary Manager wiped the area down. During an observation on 11/19/2024 at 7:31AM, a grey double shelf attached to the wall held four boxes of gloves used for food service. The grey double shelf had an unknown brownish substance that contained various white, black and brown unknown particles on the bottom shelf edging and both side edges. Directly under the double shelf were two boxes of uncovered plastic wrap used to cover residents' meal items. On 11/21/2024, a review of kitchen policy for kitchen sanitation, provided by Dietary Manger showed dietary department will be operated and maintained to meet federal and state guidelines. On 11/21/2024, a review of kitchen policy for storage of frozen foods, provided by the Dietary Manager showed dietary department will adhere to all federal and state regulations regarding refrigerated and frozen foods.

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F 0848 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide a neutral and fair arbitration process and agree to arbitrator and venue. 49413 Through record review, interviews and policy of arbitration agreement the facility failed to ensure that four of four residents sampled for arbitration agreements (Resident #7, #13,#16 and #22) or representative were clearly informed that arbitration is to be a neutral site that both parties agree to The findings are: Review of arbitration agreements signed by Resident #7, Resident #13, Resident #16, and Resident #22 with the current arbitration agreement in use, failed to provide the resident or the resident's representative notice of the fact that both parties must agree to a neutral place. During an interview on 11/20/24 at 1:30PM, the Social Director confirmed there was not anything about a neutral meeting place stated in the contracts. During an interview on 11/20/24 at 1:47PM, the Administrator stated the facility may have left something out.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 50505 Based on observations, interviews, record review, facility document review, and facility policy review, it was determined that the facility failed to ensure proper hand hygiene was performed between residents, failed to ensure cleaning of personal equipment (fan) to prevent contamination and failed to ensure Enhanced Barrier Precautions (EBP) were followed for a tube fed resident (Resident #7) of 1 resident reviewed for infection prevention and control. Findings include: A review of a facility policy titled, Handwashing/Hand Hygiene, revised in August 2019, indicated the primary purpose of hand hygiene was to prevent the spread of infections and that all personnel will follow the hand hygiene procedures to help prevent the spread of infections to others. A review of a facility policy titled Policies and Practices-Infection Control, revised in October, 2018, indicated the objectives for infection control policies were to maintain a safe, sanitary and comfortable environment; prevent, detect and investigate and control infections; implementing isolation precautions when necessary; provide supplies and equipment necessary for isolation precautions; maintaining records and corrective actions related to infections; and providing guidelines for safe cleaning of reusable resident-care equipment. A review of a facility policy titled Enhanced Barrier Precautions, revised in August 2022, stated the use of EBP is to prevent the spread of multi-drug-resistant organisms and that targeted gown and glove use is to be utilized during high contract resident care activities. EBP's are to be used for residents with wounds and/or indwelling medical devices. During an observation on 11/19/2024 at 6:25 AM, C.N.A. #2 was observed assisting with residents on 100 hall. C.N.A. pushed one resident in wheelchair to the dining room, placed resident at the dining table, left resident went over to another resident sitting further down the table and adjusted the wheelchair, then C.N.A. #2 left the dining room. C.N.A. #2 went back down 100 hall and went straight into a resident's room without performing hand hygiene. C.N.A.#2 in view of the surveyor applied a pair of gloves, then came over and shut the door to the room. During an interview on 11/19/2024 at 6:28 AM, C.N.A. #2 was asked what should happen prior to beginning care on a resident and statement was given, Wash my hands. C.N.A. #2 confirmed that prior to entering the resident's room after pushing the wheelchair to the dining room, hand hygiene should have been performed. A review of Resident #7 ' s Admission Record, indicated the facility admitted Resident #7 with diagnoses that included gastrostomy status, cerebral infarction, vascular dementia and congestive heart failure. Review of Resident #7 ' s annual Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 08/20/2024, revealed Resident #7 had a Staff Interview for Mental Status (SAMS) score of 3 which indicated the resident was severely impaired for daily decision making. Resident #7 was marked as having a feeding tube. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident #7's Care Plan, initiated on 12/07/2017, revealed the resident required tube feeding related to dysphagia. Intervention created 04/04/2024, Enhanced Barrier Precautions related to feeding tube. On 11/28/2023 a care plan was initiated for increased perspiration with body odor related to inability to regulate body temperature secondary to paralysis/hemiplegia. Intervention included, may keep fan in room related to resident's perfuse perspiration. A review of an Order Summary Report, revealed Resident #7 received water flushes, tube feeding product, and medications which were to be administered through the feeding tube. No order was documented for Enhanced Barrier Precautions or personal fan. During an observation on 11/18/24 at 11:27 AM, Resident #7 was noted to have a white fan on top of a cabinet with a grayish-brownish residue on the fan blades, around the edges of the blades and the screen. During an observation on 11/19/24 at 09:02 AM, LPN #3 was preparing medications for Resident #7 and proper technique was used during the process. LPN #3 entered Resident #7's room and placed items for the medication administration on the over-the-bed table. LPN #3 went into the resident's restroom to obtain tap water, came back to bedside, put on gloves, checked for placement by aspiration, placed syringe in feeding tube, mixed medications in water, flushed the feeding tube with 90 milliliters (ml) of water prior to administering medications. Administered the medications then flushed feeding tube with 90 ml of water. LPN #3 removed the syringe, closed the tube with plug, went to the restroom to wash out the syringe and came back to bedside and placed the syringe in a plastic bag. LPN #3 then collected remaining supplies to discard and left the resident's room. During an observation on 11/19/2024 at 9:05, Resident #7's fan was sitting on small cabinet against the wall at the foot of the bed, blowing towards the resident. The fan blades, the edges around the fan blades and the screen covering the fan were covered in a grayish-brownish residue. During an interview on 11/19/2024 at 9:10 AM, LPN #3 confirmed that the red heart signage on the name plate to Resident #7's room meant enhanced barrier precautions. LPN #3 stated I forgot all about it. Sorry, I have not worked in two months. During a concurrent observation and interview on 11/21/2024 at 10:10 AM, the Infection Preventionist (IP) nurse went with the surveyor to Resident #7's room. Upon entering the room, the fan was observed sitting on the cabinet with a grayish-brownish residue still present. IP nurse confirmed the fan was dirty and that housekeeping would be responsible for cleaning. When asked what the importance would be for the fan to remain clean, IP nurse stated that when the fan was dirty it would be blowing the dirt at the resident. During a concurrent observation and interview on 11/21/2024 at 10:17 AM, the Administrator confirmed that the fan in Resident #7's room didn't look very clean. When asked what could happen with the fan being dirty, the Administrator says it would blow the dust into the air and could cause infection and stated Resident #7 was on EBP.